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A Monthly Record of

MEDICAL AND SURGICAL SCIENCE.

EDITED BY

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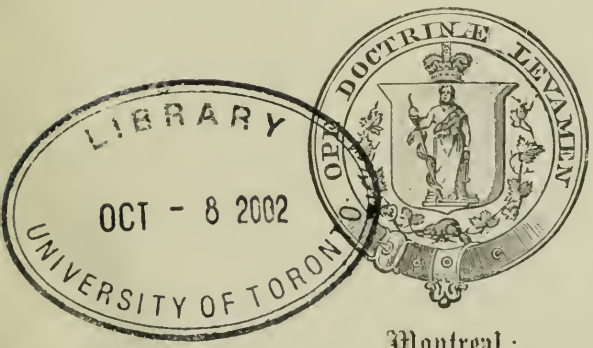

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CANADA

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Original Communications.

REMARKS UPON A CASE OF ULCERATIVE ENDOCARDITIS OF RHEUMATIC ORIGIN.

RAPID SEPTIC FORM.

By GEORGE ROSS, A.M., M.D.,
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[*Read before the Medico-Chirurgical Society of Montreal.*]

B. M., æt. 22, was admitted into the Montreal General Hospital on 4th January, 1882, under care of Dr. Ross. Was a healthy girl till three weeks before admission, when she was taken with a tender and painful swelling of both wrists and one ankle. From history of friends, she had undoubtedly an attack of acute rheumatism, though it does not appear to have been very severe. Received no treatment. No history of a previous attack of rheumatism. One week after the attack of rheumatism, or two weeks before admission, began to have severe chills, sometimes several in a day, and her friends thought she was more feverish, with bad headaches, but no delirium. Rheumatism getting better. From this time till her admission, had occasional chills, fever, headache, and altogether appeared so sick that her friends had her taken to the hospital. No delirium before admission.

Jan. 5th.—Patient has been delirious since her admission; at times delirium is wild, and she appears quite frightened, but the greater part of the time lies quietly in bed, and will answer questions, but does not appear to remember anything of her previous history. Takes a fair amount of liquid nourishment. Tem-

perature 100°F.; pulse 120 to 140, is full and collapsing. Heart apex beat is very strong, and felt in 4th interspace, just under nipple. A double murmur heard up and down sternum, and as far out as apex one can hear the systolic murmur; it is soft and blowing. No murmur at apex. Distinct pulsation of all the superficial arteries of any size, even to dorsalis pedis. Abdomen full and flaccid; no spots or tenderness. Tongue red, not coated. Lungs normal. No albumen in urine.

Jan. 6th.—Last 24 hours has been mostly delirious, at times wildly; at other times lies quietly, moaning lowly, as if in pain. Part of time was perfectly quiet. When asked, says she has no pain in head. No paralysis. Pupils moderately dilated, and when exposed to light oscillate a great deal. Pulse 135; temperature 102°F. To have Tr. Digitalis ℥ v: Pot. Brom. gr. x, every six hours, and an ice cap to be applied to head.

Jan. 7th.—Not so delirious last night. Pulse 130; temperature 101 1-5°. Point of max. intensity at third left costal cartilage, very distinct over whole precordial area, and as high as right sterno-clavicular articulation. No murmur at apex. Pupils about normal, and not dilating so much.

8th.—Still delirious, though getting quieter. No change in heart. Pupils widely dilated and oscillating very much.

9th.—Delirium last 24 hours of a more restless character; patient getting out of bed. Pupils oscillate from a pin's point to widest extent. Had three loose, dark stools, passed in bed. Slight vomiting. Pulse 125; respirations 20; temperature 102°F. No change in pulse or murmur. Has considerable diarrhœa.

11th.—Delirium the same, though she still appears conscious when spoken to. Murmurs considerably louder, though confined to same area. Pulse 128, and is failing in strength; respirations 28; temperature 101°F. Last evening patient was found to have some difficulty in swallowing, and on examining the throat a greyish membrane was found covering the edge of the soft palate and base of uvula. A quantity of secretion in the back of throat and the restlessness of patient prevents a good view of tonsils and pharynx.

12*th*.—Membrane on soft palate rather more extensive. Was very restless during the night, but to-day lies very quiet, with head turned towards right side, and eyes staring straight ahead. This has been noticed for a couple of days. Pupils oscillating. Temperature 103°F.; pulse 148; respirations 44.

13*th*.—Patient was not so restless during the night, and to-day appears more rational than she has been yet. Great difficulty in swallowing, and some of the liquids regurgitate through the nose. No change in membrane in throat. Pulse is 136 to-day, but decidedly weaker; respirations 42. Pupils not oscillating. No change in murmur. Urine examined every day, no albumen. Not much change noticed in her condition during the day, but towards midnight appeared to have some difficulty in her breathing, and died very suddenly.

Autopsy.—Body well nourished; no petechiæ. Heart not enlarged. The affection was confined to the aortic valves; the left anterior segment presented most extensive loss of substance, the greater part of the body was gone. Between the base of this segment and the attachment of the anterior flap of the mitral was a large ulcerative excavation, into which the tip of the thumb could be inserted. This passed back to the left auricle, where it was shown by four tuberous elevations near the septum. No infarcts in spleen, moderate enlargement. None in kidneys. In brain, eight or ten infarcts size of peas and one the size of a cherry in the right sulcus calloso-marginalis. The others were chiefly in the frontal lobes. Extensive diphtheritis of pharynx, larynx, and trachea.

Remarks.—There are a few points arising from this case which may, I think, be brought to the notice of the members. First, the *diagnosis* was here perhaps unusually difficult, for several reasons. One was that when first seen the patient was delirious, and we knew absolutely nothing of the nature of the onset of the severe symptoms witnessed. I then found this: a young, healthy-looking woman with high fever, flushed face, quick pulse, and active delirium. She was first naturally examined with reference to either typhoid fever or cerebral inflammation, or an acute pneumonia. Against the idea of fever was

the absence of any local abdominal signs. The belly was not full, and she did not flinch from pressure upon it, and there were no spots ; the tongue presented none of the usual furred condition. As against an acute meningitis, as far as we could get from her, she had no pain in her head, nor did she cry out or moan like a person so affected, nor had she vomited since the hour of her admission. Examination of the chest showed no signs of pneumonia ; but examination of the heart showed a moderately loud double blowing murmur in the aortic region. The condition of the circulation also showed that there was decided aortic regurgitation. The pulse was markedly collapsing, and even distant arteries could be plainly seen lifting from their beds and falling back. As soon as this was found, suspicion at once fell upon the heart as the organ primarily at fault. Still, without a history of the attack a positive opinion could not be formed. The heart disease might have been of old standing—(the only thing against this was the absence of dilated hypertrophy of the left ventricle). From the friends we learnt the following day, as I have already stated, that three weeks previously she had a well-marked, though not at all severe, attack of rheumatism ; at the end of the second week of which, and when the pains were much relieved, the fever set in—repeated chills were a marked feature at the outset, and fever, weakness and general disturbance had continued from that time. We also learnt another specially important fact, viz., that she had never suffered from rheumatism previously. Well, then, we argued, if this patient has developed such well-marked valvular disease in such a short time, it must have been produced by the destructive form of endocarditis, and that diagnosis was made. Even then another question arose, and one which I found it rather difficult to decide positively : Was there any meningitis associated with it ? I know how frequently this condition is associated with it, and, in fact, it occurred in the first case of this kind I met with. And in the present case you may have noticed in the report that a day or two later, as the delirium subsided somewhat, she lay with her head in a fixed position, and with eyes staring at a fixed spot. The pupils also oscillated exceedingly ; but in the absence of the

more marked cerebral symptoms already alluded to, I was always inclined to doubt the existence of any meningeal complication, and the autopsy showed that such did not exist.

Second, The *form* of the disease. The two forms of this disease which are commonly described by writers are the *pyæmic* and the *typhoid*. Of the latter form I recently reported a case to this Society, which no doubt many will remember. In the *pyæmic* type, the range of fever-heat simulates that of pyæmia from traumatic causes. Shiverings—these often at regular intervals, like ague. Metastases are very common. Petechiæ or pustules are seen. There are diarrhœa, swelled spleen, albumen in the urine, and generally some of the physical signs of valvular disease. In this case the range of temperatures was continuously pretty high; there were none of the fluctuations which are so often characteristic of it. In this disease there is no doubt a poisoning of the general system, as in septicæmia, from various causes, and the symptoms of this systemic infection will vary according to the manner in which the poison is introduced. If slowly, then a gradual typhoid state is induced, with perhaps occasional exacerbations as a rather larger dose is thrown in. If suddenly in large quantity, then violent indications of this toxic state are produced at the outset, and a rapid pyæmia soon brings about a fatal termination. It is to be noted also that even this most rapidly fatal course may be taken without any of the local internal derangements brought about by the detachment of emboli and the consequent infarctions in various organs. I am not aware that any attempt has yet been made to show, if possible, upon what local differences these two forms depend: Why one man with an extensive valvular lesion and immense fungous growths lives for many weeks, dying only in a state of utter exhaustion and emaciation; and another, with perhaps much less local trouble, is cut off very quickly, with indications of an overwhelming poisonous dose having been received.

Third, The association of this disease with acute rheumatism. The statement is made by nearly all the authors that septic endocarditis is *often* the direct result of acute rheumatism. But it is a singular fact that when Dr. Osler came to analyse all the

reported cases he could find, it was shown that only a very small per cent of the whole were so associated, from which he inferred that this statement could not be supported. However, three cases which have recently come under my own notice were certainly directly preceded by inflammatory rheumatism. There would seem, though, to be no kind of connection between the severity of the rheumatism and the outbreak of this septic disorder. In this case the attack was said to have been mild—so much so that she had no treatment for it.

Fourth, I would note that this patient never had rheumatism before, and had been in excellent health; had therefore had no known symptoms of valvular disease; and then that the autopsy showed that all the parts of the valve-segments, except that directly involved in the fungating and ulcerating disease, were quite normal. It affords us therefore an example of a *primary* affection. Several cases which I have seen in the practice of the General Hospital have been subsequent to diseases of the valves of old standing, and this fact has again been recently insisted upon by Dr. Goodhart in a discussion at the Pathological Society of London.

Fifth, The occurrence of *Diphtheria.* During the course of this autogenous pyæmia, well marked diphtheria was seen—on the soft palate, tonsils, pharynx, and inside the larynx. Did this sick woman contract the disease in the Hospital? Several cases were there, and some in the next ward had recently suffered from it. It was therefore possible. But I do not think it was likely. Diphtheric exudations do occur in persons the subject of septicæmic states. They may occur in a great many parts, and, of course, amongst these, upon the parts usually the site of the contagious disorder. Coming on as it did here, this was most probably the case in our patient. If this explanation be the correct one, was that throat a source of contagion? It *may* have been, but as it was particularly inconvenient to have her isolated, this was not done, and, certainly, no ill effects followed from it.

The following case, previously observed, is worth recording, as furnishing for comparison a good example of the typhoid type sometimes assumed by this disease:—

Case of Ulcerative Endocarditis—Typhoid symptoms, somewhat prolonged duration—Death—Autopsy.

H. M., æt. 38, admitted under Dr. Ross, 8th Sept., 1881. Good family history; no tubercular antecedents. Always had good health until his present illness. About one month ago began to complain of chilly feelings, with fever and sweating; weakness, pains in the knees, loss of appetite, and some vomiting. During second week had one attack of epistaxis. Kept going about until ten days ago, when a physician told him he had fever, and ordered him to bed, with low diet. He then had increased weakness, and began to suffer from severe pains in the joints. For this he used a strong liniment of hartshorn and oil, with which he severely blistered the skin around them. His wife thinks that the parts were not swollen or red. During the whole time he has had almost constant fever and general feeling of *malaise*; a relaxed condition of the bowels, but no diarrhœa.

Status Præsens.—Patient looks dull and heavy; face slightly flushed; pupils not dilated; tongue moist and coated of a dirty whitish-brown. Complains of pain, of a stitch-like character, in left lower costal region. Abdomen not distended; no tenderness nor eruption. Heart apex in 5th space, dulness normal; a loud whiffing, somewhat musical murmur is heard at the apex—systolic—and transmitted as far as the mid-axillary line and to the ensiform cartilage. At the base the first sound is indistinct, and the second is sharp and flapping, followed by a suspicious murmurish sound. Temperature 100½°; pulse 102. No swelling in any of the joints. Urine normal.

The condition as thus described continued without material change for some time. No chills are mentioned, but the fever ranged high, with marked remissions—sometimes to normal or even subnormal in the mornings. The state of prostration marked. On the 15th, tongue very dark-brown in the centre. Iliac tenderness (?). Three stools in the day, loose, watery, yellowish-brown. During the next week the temperature ranged from 100° to 103°; no chills; weakness increased; tongue moister; perspires very freely, specially at night; some pain under left ribs, where, also, tenderness is considerable. Pulse 90 to 100, intermittent.

On Oct. 3rd, fever and prostration continue; not so much sweating. The mitral systolic murmur is now heard all round the left side to the spine; it is very loud at the back. The slightly prolonged and altered second sound is heard as before.

Oct. 6th.—Temperature now remains without much variation, about 102°. Slight delirium at night. Small quantity of albumen in the urine. Pulse more irregularly intermittent, getting very weak.

Oct. 10th.—Nocturnal delirium. Great tenderness of skin over toes of left foot. Stiffness and pain in right wrist and elbow. Pulse weak and intermittent.

Oct. 14th.—An eruption of small petechial spots over the abdomen.

From this time rapid exhaustion set in, with increasingly feeble pulse; rather lower temperature, 99°–101°; delirium; stupor; occasional sweatings, and he died on the 23rd.

Autopsy.—Body emaciated; a few cutaneous petechiæ. Heart was a little enlarged. Both mitral and aortic segments presented ulcerative vegetations. On the mitral, the anterior segment was the seat of a recent valvular aneurism the size of a cherry, the orifice on the ventricular face rough and covered with many vegetations. The two anterior segments of the aortic valves were united and thickened; the single segment was the seat of numerous soft, greyish vegetations, one of which hung by a very slender pedicle. Left ventricle a little hypertrophied. Spleen weighed 300 grms., and presented six or eight infarcts; one, the size of a billiard ball, had suppurated. No infarcts in kidneys. No special changes in lungs, brain, or other viscera.

ABSTRACT REPORT OF THE FOURTH ANNUAL CONGRESS OF THE AMERICAN LARYNGOLOGICAL ASSOCIATION.

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a Fellow of the Association.

The American Laryngological Association held its fourth annual meeting in the Hall of the Medical Library Association,

Boston, June 12th, 13th and 14th; Dr. Knight occupied the Presidential chair, the vice-chair being filled by Dr. Shurley, the First Vice-President.

The President opened the proceedings with the usual address and referred at length to the progress of Laryngology during the past year, which he considered satisfactory. At the International Medical Congress in London the subject, though only allowed a sub-section, produced papers and discussions universally admitted to be among the very best of the Congress. Several of the Universities had recognized the study by the establishment of Professorships, though lack of time would prevent much prominence being given to the subject. Though the advance had been satisfactory, it was capable of much greater development. He pointed out two distinct duties that should be held in mind: one to foster the specialty and improve it—the other to the general profession and the community in which we live to make our knowledge of the greatest benefit to mankind. The first of these duties were discharged by our individual studies and researches into the nature of Laryngeal and allied diseases and the proper method of treating them, by our contributions to special journals, and by our papers and discussions in this Association. The second duty involved the consideration of the best means of ensuring that amount of knowledge of our specialty, particularly of the methods of examination which every practitioner of medicine should possess. The community were not slow to learn the real advances in our art, and were now pretty generally aware that a physician was not fulfilling his duty to them when, for instance, he gave an opinion on the cause of hoarseness and prescribed a remedy for it without using the Laryngeal mirror. An important point was to teach the intelligent use of the instrument. If a student neglected the acquisition of the use of the Laryngoscope during pupilage, he would not likely acquire it afterwards. Continual personal and individual supervision was inadmissable. Large classes of men could not be instructed at once, and demonstrations—the most valuable and practical part of the instruction—could not be enjoyed by more than three or four at most at a time, and, consequently, the labor of the teacher became ardu-

ous from its oft-repetition. He advocated the four years' course as sufficiently short a time in which to acquire a well-rounded medical education and deplored the commercial character of too many of our modern schools, and expressed the hope that the rendering of teachers independent of class fees, by the introduction of endowments, would some day remedy the prevailing evil of competition for students, so detrimental to modern medicine.

Among many other topics he referred, in concluding his address, to the Association, its meetings and papers, and the good-fellowship and cordiality that had thus far characterized its gatherings. The Association had limited its fellowship to recognized teachers in leading schools, not to exceed fifty in number, a figure now attained, and he hoped that should vacancies occur by any means that the *personnel* would still be jealously maintained. He then introduced the papers of the day, and wished the Fellows a pleasant and a profitable session.

"Paralysis of Muscles of the Larynx," by Dr. Elsberg, of New York, was the first announced. This paper, like all others emanating from the pen of this talented gentleman, showed great detail and thoroughness of research and originality of thought. He had for many years named the laryngeal muscles from their position as well as main action And in regard to the action of the intrinsic muscles gave it as his opinion that the thyroid cartilage was fixed relatively to the movement between the several parts of the larynx. He gave the muscles influencing the vocal bands as follows :—

1. Anterior muscles, the thyro-cricoid ; tensors of the vocal bands.

2. Interior muscles, the thyro-arytenoid; straighteners of the vocal bands.

3. Transverse muscle, the arytenoid ; transverse adductor of the vocal bands.

4. Lateral muscles, the lateral crico-arytenoid ; lateral adductors of the vocal bands.

5. Posterior muscles, the posterior crico-arytenoid ; abductors of the vocal bands.

Those whose anatomical names were derived from two cartil-

ages, the first two and the last two muscles, were bilateral; those whose anatomical name was one word, was a single muscle. The first four may be grouped together as constrictors, or narrowers of the rima. The fifth comprises the group dilatators, or wideners of the rima glottidis. Paralysis of the constrictors of the rima glottidis caused "phonatory leakage" of air (Elsberg), paralysis of the dilatators "respiratory insufficiency;" in the former case the characteristic laryngoscopic image was obtained in the examination during efforts of phonation; in the latter during respiration. In each of the isolated paralyses of, and in combined paralyses confined to, the constrictor muscles, respiration was not directly interfered with; nevertheless, in all severe cases the patient suffered from easily getting out of breath on account of the leakage of air, while in the isolated paralyses of the dilatators, the voice, though never extinct, is not clear and pure on account of incomplete fixation of the arytenoid cartilages. He proposed a scheme for deciding by the shape of the gape the form of the paralysis and the muscles engaged. Though very ingenious, it would require very deep thought for its mastery. Among other interesting points he further stated, that, when in injury or disease of either the brain or the pneumogastric, spinal accessory or recurrent nerves, laryngeal paralysis is or becomes incomplete, a very curious and yet unexplained fact has been observed, viz., that the abductor filaments are more prone to be affected than the adductor filaments, and that if, in a case in which both the abductors and the adductors are affected, recovery takes place, the adductors are apt to recover first or exclusively, and to be affected with abnormal contraction, so that the patient during the progress of recovery is in danger of a dyspnœa, which might necessitate tracheotomy to prevent death. The relatively greater disposition to implication of the abductor filaments is well known to laryngologists, but the relatively greater disposition to recovery of the adductor filaments under these circumstances seems to have been unnoticed until Dr. Elsberg himself called attention to it. In the discussion that followed some exception was taken to calling the thyro-arytenoid muscle a

straightener of the vocal bands—it was true it was only one of its functions, but as such it had been *tacitly* recognized by every laryngologist. When these muscles were paralyzed the vocal bands were concave, and when in action straight. If one of the functions was not to straighten the cords, Dr. Elsberg was at a loss to account for this fact. Space prevents the minute detail this paper so well deserves, and which, to do the author justice, it would require.

"On Laryngeal Asthma," by Dr. Glasgow, of St. Louis.

Dr. Glasgow claimed that the dependence of bronchial spasm upon laryngitis had not been previously noticed. Several writers on asthma had described such cases without really recognizing the true seat of irritation: and had universally included the condition under the term Bronchial Asthma, presupposing the point of irritation to be located in the bronchi. They had, in some of these cases, noticed that the signs of bronchial inflammation only become apparent after the asthma has existed for some time. Such cases he considered primary laryngitis, with subsequent extension to the bronchi. Under laryngeal asthma he would not include those symptoms so often met with in laryngitis, such as laryngeal whistling, laryngeal râles, and the sensation of suffocation which is often found accompanying an inflammation and œdema of the posterior surface of the larynx, and would also exclude laryngisum stridulus. His attention was first drawn to the occurrence of bronchial spasm as a result of laryngitis through the unexpected results of an application to the larynx in the case of a child suffering from an attack of asthma. Dr. Glasgow reported at length six cases he considered typical, and said he had met with nine in addition; in all he found two prominent factors, a subacute inflammation of the larynx and bronchial spasm. The condition of the larynx was demonstrated by the mirror, and the bronchial spasm by the physical signs—sibilant and sonorous râles and the prolonged expiratory effort characteristic of the asthmatic. He also found an improvement or a disappearance of the asthma as a result of applications to the larynx. Dr. Glasgow had found relief to be instantaneous in some cases, in others more gradual, and claimed

that we should not locate the point of irritation in the bronchial tubes without some evidence of a pathological change of their mucous membrane. He did not deny the dependence of asthma upon bronchial inflammation, nor that it may coexist with a laryngitis; in such cases the spasm continued after the cough had yielded to local treatment. That hay asthma depended upon irritation of the laryngeal mucous membrane he was convinced, as relief quickly and permanently followed laryngeal applications. Laryngeal asthma he held to be reflex, examples of which were numerous—as nasal asthma due to nasal polyps—cases in which the olfactory nerves play an important part, as in asthma arising from emanations from flowers and animals. The presence of food and a loaded condition of the bowels were well known and recognized causes of asthmatic phenomena. The treatment of this asthma consisted in the treatment of the primary lesion—the laryngitis. The usual remedies had recourse to in asthma may also assist, but the relief they afford will be only temporary, and no permanency will be secured until after the disappearance of the laryngitis.

"On the question of Hypertrophy of the Osseous Structure of the Turbinated Bodies," practically considered by Dr. D. Bryson Delavan, New York. Dr. Delavan stated, in introducing the subject, that in all recent contributions attention had been directed solely to the consideration of the soft parts, while the investigation of the fundamental structure of the organ, its osseous tissue, had been ignored. The object of his paper was to establish the proposition, that *the turbinated bones may, under proper conditions, undergo marked hypertrophy.* Theoretically, the process of hypertrophy might occur in almost any tissue of the body. Hypernutrition was, of course, the occasion of hypertrophy in bone as well as in other tissues, and to such structural changes the bones of the skull were particularly liable. The turbinated bones were not formed until a late period in the development of the fœtus; indeed the inferior turbinated bone was ossified from a single centre, which only appears at birth. This tardy appearance implied activity of development later in the history of the child, and it was not unreasonable to suppose

that occasionally actual overgrowth might occur. Atrophy and hypertrophy, though antithetical conditions, there was no part which being susceptible of the one was not equally so of the other. Atrophy of the bones, in atrophic rhinitis, was commonly met with and conceded ; then, under conditions of nutrition exactly opposed, why not the opposite condition of hypertrophy of these bones ? The probability was increased when we considered the facilities afforded by the intimate relation between the mucous membrane and the bone through the medium of the membrana mucosa, which not only formed a fibrous network for the support of the vessels but also passed into the periosteum. Dr. Delavan gave, as the conditions favorable to hypertrophy of the turbinated bone—1. Unusual space in the nasal fossæ. 2. Long continued hyperæmia of the structures investing the bone. 3. The existence of the above two conditions during the period of greatest constructive activity.

Too free inspiration of air through the nares will produce turgescence of the nasal mucous membrane, and when long continued, chronic hyperæmia. Persons whose nasal cavities were unusually large were, preferably, subjects of nasal catarrh. In the normal nasal chamber the erection of the tubinated corpora cavernosa was limited by the boundaries of the nasal cavity. The greater the possibility for expansion and the more exposure leading to congestion, the less likely were the soft parts to return to their normal conditions of size and nutrition, and, of course, the greater the hyperæmia of the soft parts the greater the hypernutrition of bone. Commencing early in life, the maximum would not be reached until the adult period. With a spacious nasal fossa, a turbinated body abnormally stimulated, a turbinated bone excessively nourished, and a subject preferably rachitic, in whom the constructive process is at its height, there is no reason in theory why the bones should not increase in size equally with the hypertrophy of the soft parts. The conditions which would best furnish these factors would be congenital, and would be found in cleft palate and in deviation of the nasal septum. Cleft palate was, however, as rare as deviation of the septum was common, so that we may devote our attention to

this latter condition. Deflection of the septum may result at any time during life as the result of fractures or dislocations, or from intro-nasal growth pressure, but these causes were rare. Deviation had been supposed to be due to habitual blowing of the nose. This was not likely, as it occurred in races, especially the negro, with whom the use of the handkerchief was uncommon or unknown; moreover, the curve was seldom, single, confined to the front, but usually double, and extending too far back to be affected by lateral pressure upon the anterior aspect. Reasoning by exclusion, then, the congenital origin of a large number of cases of deviation was evident. The middle turbinated bone was the one most commonly enlarged; and since the septum was in a plastic condition some time after birth, the question might arise, Was the turbinated enlargement due to a deviation, or the deviation the result of the hypertrophy? The latter was negatived by two facts: in the first place, nature is rarely asymmetrical, so that enlarged turbinated on one side would be accompanied by the same condition on the opposite side; and in the second place, the greatest enlargement was found on the side of the greatest concavity. By a very extensive and minute investigation in craniological museums, dissection of fresh subjects, and exploring in the living, Dr. Delavan had been enabled to verify the foregoing conclusions. The middle turbinated was most commonly affected, and the enlargement extended throughout the whole antero-posterior course of the bone; it had nothing about it of the nature of exostosis; the bony plates were of about the same relative thickness as in the normal organ, the whole resembling a natural turbinated magnified in size. In some instances the bone was thinner, when the general symmetrical hypertrophy was by no means constant, but rather seemed to follow the course of the deflected septum. It would be seen that any operation for the relief of the stenosis referred to the septum would only aggravate the condition by increasing the tendency to hypertrophy. Removal of the turbinated bone itself was essential, and must first be effected, then the septum may be corrected, but the reverse order of procedure must not be followed.

Zuckerkandl of Vienna speaks of "a bladder-like expansion"

of the turbinated bone, which would correspond to one of the forms of *dilatation* referred to by Dr. Delavan. Dr. Delavan's paper was timely, and its practical nature cannot but recommend it for perusal and careful consideration, and has undoubtedly the merit of priority.

"On Photographing the Larynx," by Dr. T. R. French, Brooklyn, N.Y. Dr. French has succeeded in securing some very good results. He used sun light—a small camera, mounted on a tripod. The throat was illuminated with a plane mirror with central aperture §in. in diameter. The throat mirror was attached to a flexible rod fixed to the top of the camera. The plates were exposed from one to four seconds; none of the pictures showed the entire larynx. Dry gelatine plates were used, which simplified the matter very much. The great trouble was that when one portion of the laryngeal image was in focus the rest of it was out, so that it was impossible to get a really perfect picture. Schmidt and Stein had both photographed the larynx, but Dr. French's results were superior. The burning magnesian wire or electric light might have been used with some advantage. Field, lately of Montreal, with my assistance, produced, three years ago, some very good pictures of laryngeal cancer. The results were shown to the Medico-Chirurgical Society at the time of my reading my paper on the case.

"Ozæna," by Dr. Bosworth, New York. Dr. Bosworth opened the discussion, for the object of his paper was such, by asking, What was meant by ozæna? The term simply conveyed the idea of a stink—to use a forcible but not an elegant term; a single symptom gave rise to the name, much in the same way as "dropsy" gave rise to confusion in early medical nomenclature. The term ought either to be abolished (the better plan) or else confined to one well known condition attended with offensive odor, rhinitis atrophica. Fetid discharges from the nose occurred under five conditions—1. Syphilitic ulceration and necrosis. 2. Scrofulous ulceration and necrosis (rare). 3. Presence of foreign bodies. 4. Disease of one of the accessory nasal cavities. 5. The late stage of atrophy of the nasal mucous membrane, the rhinitis atrophica

of the Germans. Syphilis and scrofula give rise to typical and characteristic symptoms and morbid conditions, hence he held that whether in the nose, larynx, skin or elsewhere, it was to be considered under its original name. Cancer and lupus give rise to offensive discharges, as do also sometimes diphtheria, scarlatina and typhoid fever, &c., but as the origin of the discharge was easily recognized they should not add to the general confusion. There come under notice very frequently cases of nasal catarrh with a fetid odor, in which there is seen, on inspection, a nasal cavity large and very roomy. The turbinated bones, especially the lower, have nearly all disappeared, and the cavity is lined with greyish green crusts adhering closely to the mucous membrane. The odor is fetid and offensive, but by no means so penetrating as that of syphilis of the nose. If we thoroughly detach these crusts and clean the cavities we find the odor removed, and furthermore we find the mucous membrane intact and unbroken. There is no ulceration, no abrasion and no necrosis. Nothing more remains to recognize the disease but a roomy cavity and shrunken turbinated bones; it is rhinitis atrophica—it is a purely local disease, a catarrhal inflammation of the mucous membrane, and atrophic from the first. The disease commences in early life, in an inflammation characterized by a desquamation of the epithelial lining of the acinous glands. There ensues a marked diminution in the number of glands, and the membrane is deprived of its normal supply of mucus. What is secreted is scanty and soon dries, leaving a thin pellicle, which closely adheres, and is removed with difficulty; it then decomposes and gives rise to fetor. The secretion beneath the pellicle going on is imprisoned, and a new source of fetor is developed. The mucus held becomes purulent and infects the membrane, and a still further secretion of pus results. Under the process of drying, contraction occurs, and the circulation is interfered with, and is still further obstructed by the fresh secretions of pusy mucous under the pellicle. Thus atrophy takes place.

The extent of the atrophy of the turbinated bone may be looked upon as a measure of the duration of the disease. As to the cause

of the disease, Dr. Bosworth knew of none. It occurred, as a rule, in patients in good health ; it might involve one or both nostrils, or a portion of one, or both. The treatment Dr. Bosworth would employ might be foreshadowed by what has already been said. While disinfection of the cavities is important, a stimulating treatment will be called for. The fluid used for cleansing should be alkaline, for its solvent effect on mucus; and it should be disinfectant, to correct results of decomposition. Carbolic acid 1 grain with 3 grains each of bicarbonate and biborate of soda to each ounce of water is about the best cleansing fluid. This should be used with a post-nasal syringe, and should be employed twice daily ; if syringing will not dislodge the crusts, they must be removed with cotton wool pellet on a proper probe. After cleansing thoroughly, stimulating applications should be made. A radical cure is doubtful if the disease be old. The extent of the atrophy of the turbinated bones is always an evidence of the curability, as it is of the chronicity likewise. For ordinary use, after all fetor has been corrected, common salt is a good and useful adjunct to what has been already recommended.

This paper was one of the most clearly written, most simple as an exponent of the author's views, and as thoroughly in accordance with rational ideas on the subject as any produced at the congress.

BI-MONTHLY RETROSPECT OF OBSTETRICS AND GYNÆCOLOGY.

Prepared by WM. GARDNER, M.D.,
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The Treatment of Puerperal Convulsions.—Breus, assistant at Prof. Gustav Braun's Obstetrical Clinic at Vienna, in a paper in the *Archiv. f. Gyn.*, Bd. 19, Hft. 2, gives the results of the treatment of puerperal eclampsia in the clinic by hot baths and packing. The cases selected for this treatment were those in which the presence of albuminuria and dropsy indicated copious sweating. This treatment was not used to the exclusion of nar-

cotics. These were used when necessary to control the convulsions. The results were most favourable. Of six cases so treated, only one died. In this case the kidneys were found in the second stage of Bright's disease ; œdema of brain and lungs and cirrhosis of the liver were also present. In some of the favourable cases in which the convulsions came on before the expiration of the full period of gestation, the œdema and albuminuria ceased or greatly abated, and the patients went on to full term. No ill results were observed from the treatment. It appeared in no wise to excite or affect the progress of labour, nor when administered after delivery did the baths have the least tendency to relax the uterus or favour hemorrhage. The puerperium, moreover, was not at all unfavourably affected.

The baths and pack were administered in the following manner :—The sick-room was kept at 20°C. The patient was put in a bath at 38° to 40°C, and this was then warmed up to 42–45°C. by the addition of hot water. The body was immersed to the chin, and kept in the water for half-an-hour ; while in the bath, copious sweating of the head and face was noticed. The bed was prepared for the "pack" in the following manner :— Two blankets were spread on it, and over these a warmed sheet. As soon as removed from the bath, the patient was wrapped in a warm sheet, put into bed, and there covered with several blankets, the face only remaining exposed. Copious general perspiration soon resulted, and the pack was continued from two to three hours and repeated daily for as many days as might be necessary. As a result of the treatment, the author concludes that since no ill results followed in these cases, the induction of copious diaphoresis by hot baths and packing is as much indicated in the treatment of puerperal eclampsia as of Bright's disease, in which its value has been long recognized.

Case of Basilysis, by Prof. A. R. Simpson, Edinburgh.—The report of this case appears in the *Edinburgh Med. Journal* for last March. A description of the operation of Basilysis, as proposed by Professor Simpson, will be found in the October (1880) number of this Journal. Briefly, it consists in perforating first the vault of the skull, and subsequently the hard and un-

yielding base, by a suitable instrument, the "basilyst," in order to facilitate the delivery of the head through a contracted pelvis. In this case, after the comminution of the head, its delivery was easily accomplished; extraction of the body was, however, more difficult. Dr. Simpson believes that the result justifies his preference for this operation over cranioclasm or craniotomy. He believes basilysis to be an easy, safe and satisfactory operation. This is the first opportunity he has had of trying the instrument on a child in utero.

Ligatures around the Extremities as a means of Hæmostasis in Uterine and other Hemorrhages.—Dr. J. W. Pryor of Lexington, Ky., in a short paper in the *Amer. Jour. of Obstetrics*, July, 1882, calls attention to this method of arresting hemorrhage. Dr. P. does not claim priority or novelty for this treatment, but asserts that it has been forgotten or neglected. He believes that not only is it a means for hæmostasis, but also for prevention, almost infallible, in cases where, from facts in the previous history, hemorrhagic diathesis, &c., there is reason to fear flooding. The material used by the author is elastic web, one inch wide (taking a somewhat narrower ligature for the upper extremity), with a buckle similar to that found upon the common Arctic overshoe. Unbleached cotton or any heavy material may be used. The mode of application, either as a preventive or as a remedy when hemorrhage has actually set in, is to tie the ligatures around each extremity as close to the body as possible, drawing them tight enough to arrest the return of the venous blood, without materially affecting the arterial circulation. Two cases are given in illustration of the good results of the treatment in puerperal hemorrhage. In three other cases, one of repeated pulmonary hemorrhage and two of intractable epistaxis, the bleeding was speedily controlled by ligatures around the arms until internal remedies had time to act in permanently arresting it. In the case of hemoptysis, several recurrences of the bleeding took place when, by way of experiment, the ligatures were omitted and internal remedies alone given, until the exhausted condition of the patient demanded prompt action. The ligatures were then applied, and the hemorrhage was immediately checked.

The Relation of Lateral Cervical Lacerations to Catarrh of the Cervix Uteri and the Necessity for Emmet's Operation.—This is the title of what I believe to be the most important paper on these subjects that has appeared since Emmet's original papers on Laceration of the Cervix. The author is Prof. Carl Schrœder, of the University of Berlin. He first adverts to the fact that there is a great want of uniformity of good results after the now very frequently performed Emmet's operation, showing, in his opinion, that the indications for the operation are not yet clearly defined. In the great majority of cases, cervical catarrh exists as a complication of the laceration. What is its relation to the laceration? Emmet says it is usually a consequence. Schrœder says, on the other hand, that it is usually the cause. In support of this he argues that deep lacerations, not rarely extending into the vaginal junction, are often found completely healed when we are searching for other conditions. No one would think of performing such an operation with a view of curing cervical catarrh. Any gynecologist of experience knows that the most obstinate cases of catarrh to cure are those in which the cervix is narrow. Emmet himself insists on getting the parts into healthy condition, and devotes, if necessary, several months to this object before he operates.

Are cervical lacerations alone, uncomplicated with catarrh of the cervical mucosa, of sufficient importance to render the operation necessary? In the author's experience, as a rule, they are not. There are exceptions chiefly belonging to the following type: Deep, double-lateral lacerations, with complaints of pelvic pains, increased especially by exertions and straining, and functional disturbances in the use of the lower extremities. In such cases there is usually a pronounced tenderness of the angle of the fissure when touched with the finger or the sound. Ectropion is also considerable, and the author believes that in the main the pains are due to the dragging at the angles of the rents. In a few cases manifold nervous symptoms attend. In such cases it is imperative to undertake the repair of the cervical lacerations. But these are not numerous. It is more difficult to decide in regard to cases in which cervical lacerations and

catarrh are present at the same time. As already mentioned, Schrœder does not believe that the cervical catarrh is due to the laceration. It must be admitted that catarrh of the cervix is common when the os is intact. All that we see before the os is incised is a ring of erosion, with a string of mucus hanging into the vagina. Again, the exposed cervical mucosa does not tend so much to catarrhal affections as to transformation of its cylindrical into pavement epithelium. This latter condition is frequently observed in prolapsus, in which the lips, to the extent of their eversion and exposure, are often covered with pavement epithelium exactly resembling that of the remaining vaginal mucosa. In support of his position, that the cervical catarrh causes the laceration, the author argues as follows: During childbirth, lacerations of the margin of the external os are of regular occurrence; they are sometimes only superficial, but sometimes they extend deeply into the cervix. As a rule, these heal during the involution, because their margins lie together and adhere, leaving only slight cicatrices. But if their edges do not lie in contact, they will not unite. This non-apposition is produced by the catarrhal, hyperplastic, and therefore everted mucous membrane, which inserts itself into the gap and prevents union; and this is the cause of the great frequency of the complication of cervical lacerations with cervical catarrh. For these reasons the author holds it to be incorrect to neglect the catarrh and to cure the laceration at once by Emmet's operation, and maintains that the catarrh is, pathologically, of the greater importance, and that its treatment must be placed in the foreground. For the same reason Emmet's operation is to be contraindicated while the cervical catarrh persists, because the gaping cervix greatly facilitates the local treatment of the catarrh, and the closed cervix renders it more difficult. He then goes on to say: "The treatment of chronic cervical catarrh, complicated with great tumefaction, deep indentations of the mucosa, and manifold glandular proliferations, however, is difficult, and requires a protracted length of time." Astringents and caustics temporarily improve, but do not readily cure the condition. The hot iron may cure if used energetically. The author has not

tried it, dreading the destruction of the mucous membrane, with the quite uncontrollable cicatricial contraction that may result. He therefore recommends his own operation of excising the diseased mucous membrane, by which chronic intractable cervical catarrh may be quickly and safely treated. The uterus is drawn down as far as possible by inserting a double tenaculum forceps into both lips. A stream of three per cent carbolic solution is allowed to flow over the field of operation during the entire time of its performance. The two lateral lacerations are then incised with scissors even when they extend as far as the vaginal vault. If now the two lips are widely separated, the diseased mucous membrane may be excised to any extent. To this end a transverse incision is made near the level of the internal os, terminating at the lateral incisions on both sides. This incision should divide not only the mucous membrane, but penetrate some distance into the wall proper of the cervix. A similar transverse incision is then made, likewise extending from one lateral rent to the other, externally, at the extremity of the vaginal portion, or rather in the mucous membrane, at the junction with the morbid portion, and the piece thus circumscribed is excised in nearly a wedge-shape. Sutures are then introduced in such a manner as that the margin of the wound at the extremity of the vaginal portion is joined to the margin of the wound in the mucous membrane above in the cervix. The posterior lip is treated in the same way. It is now optional with the operator how far the cervix is to be united laterally. By this operation Schrœder claims that the catarrhal mucous membrane is removed, excepting a short stump at the internal os, and the lateral lacerations are made to disappear. Thus both indications are met by one operation. The author says of this operation: "I have performed it frequently; I know it to be easy, certain to succeed, and entirely free from danger, and therefore recommend it warmly." He concludes his paper as follows: "My opinion, consequently, is that in cases where there are only cervical lacerations without catarrh, Emmet's operation is indicated whenever troublesome symptoms appear which are referable to the lacerations. In these, unfortunately

rare cases, it is a beneficial, at times almost magically effective operation, and a very important advance in operative gynæcology always to be linked to the name of Emmet. But in co-existing cervical catarrh the latter is of greater importance, and in these cases it is better, instead of first treating the catarrh and then repairing the lacerations, to excise the morbid mucous membrane and to unite the lacerations simultaneously by one operation"'—(*American Journal of Obstetrics*, July, 1882.)

Operations for Restoring Complete Lacerations of the Female Perineum through the Sphincter Ani, by Dr. H. T. Hanks, Assistant Surgeon to the New York Woman's Hospital.—The author, after remarking on the difficulties of the operation and its frequent failure, as exemplified by the experience of the surgeons to the Hospital, proceeds to say that he prefers Emmet's operation for all cases where the perineum and sphincter ani only are involved, but that Simon's operation is the best for closing extensive rents of the rectum and sphincter.

Dr. Hanks believes, and his opinion coincides with that of an increasing number of eminent operators, that the principal cause of failure is in the treatment of the bowels. He urges the necessity for securing daily thorough action of the bowels for a full week before the operation. By this method the bowels are thoroughly emptied, and a knowledge is gained of the dose necessary to liquify the evacuations when laxatives come to be given after the operation. Hypercatharsis is thus avoided. After the operation, on the second day, and on each succeeding day till the tenth, the laxative that seems best suited is given in sufficient quantity to produce liquid evacuations.—*N. Y. Med. Record*, July 11, '82.

The Relation of Anteflexion of the Uterus to Dysmenorrhœa.—This was the subject of a paper read before the Obstetrical Society of London by Dr. Herman of the London Hospital. The author first reviews the generally accepted theory that dysmenorrhœa with anteflexion is caused by constriction or temporary closure of the uterine canal at the point of flexion. With reference to the commonly held opinion that the flexion takes place at a sudden angle, as is often shown in drawings, Dr. Herman,

in four specimens in the London Hospital museum, found a gradual flexion, no sudden angle and no dilatation of the cavity of the uterus. He also sought in vain to discover any case in which the menstrual blood had been retained, and dilatation of the uterus induced, when it could be traced to no other cause than anteflexion. Neither could he find any case of pelvic hæmatocele, depending on stenosis of the uterine canal, caused by anteflexion. The most important, as well as the most valuable, part of his paper is the result of his own experience. He asserts that evidence adduced from observations made on subjects who complain of dysmenorrhœa is one-sided. If it be admitted that in many such the uterus is anteflexed, the question may be pertinently asked: "Is the uterus anteflexed also in other women who do not suffer from dysmenorrhœa." It is only by answering this question—that is, by discovering the proportion of women who suffer from dysmenorrhœa with and without anteflexion, and of those with straight and anteflexed uteri who do not suffer from dysmenorrhœa—that the part played by anteflexion in producing menstrual pain can be determined. With this object in view he examined 110 women who sought relief for suffering, other than uterine. He found that out of 57 women in whom the uterus was only slightly or not at all anteflexed, in 40, or 70 per cent., there was little or no pain at the menstrual period, and in 17, or 29 per cent., there was severe pain. Out of 53 women, in whom there was pronounced anteflexion, in 37, or 69 per cent., there was little or no pain at the menstrual period, and in 16, or 30 per cent., there was severe pain. He concludes, therefore, that menstruation is as often painful when the uterus is straight as when it is anteflexed, and that it is as common for menstruation to be painless when the uterus is anteflexed as when it is not anteflexed. The value of observations of this nature is obvious. If the facts proved by Dr. Herman were generally known and believed, the treatment of dysmenorrhœa, as practiced, would be considerably modified.

Membranous Dysmenorrhœa cured by Mercury.—The writer, whose name is not given, relates five cases of this most obstinate complaint which he cured by the drug mentioned. It was by

a rather unpleasant accident that he discovered the efficacy of mercury in cases which, from the known virtues of this agent in all forms of acute or chronic hyperplasia, might *à priori* have been supposed to be amenable to it. In this case the author had dilated the uterus a few days before the period, with a view of relieving the pain. This set up metroperitonitis. For this she was given calomel and opium, and by mistake a much larger quantity of the medicine was given than intended, with the result of producing salivation, but the menstrual flow had also been started without pain or discharge of any membrane. For five years afterwards the dysmenorrhœa had not returned. In four other cases mercury was given in quantity sufficient to touch the gums for a few days previous to the advent of the period, and with the result of curing each one. The remedy certainly deserves a trial in the treatment of an affection which so generally baffles medical skill.—(*Med. Record*, quoted by the *Cincinnati Obstetric Gazette.*)

Iodoform in Gynecological Practice.—Dr. F. P. Foster recently read a paper before the New York Materia Medica Society on the uses of iodoform. Amongst other results he stated that he had found it useful as a sorbefacient in chronic extra-uterine exudations. He applies it to the upper part of the vagina, and then applies a tampon below. This acts mechanically, retaining the vapor. In dysmenorrhœa the drug gives great relief, but does not control the pain in subsequent menstruations. He has found it of great use in pruritus vulvæ and hyperæsthesia of the vulva. He had considerable confidence in its discutient action in cervical hyperplasia.

Drs. Smith, Mundé, Bosworth and others took part in the discussion. Dr. Mundé stated his practice of using the drug in cervical erosions, endotrachelitis, chronic pelvic peritonitis, erosions of the vulva and vagina, and hyperæsthesia in a case of caruncle of the meatus. In each of these conditions he has found it to be most valuable. Dr. Lusk had found it very successful in fissures of the anus. He applied it to lamp-wick, which he draws through the fissure.

Dr. Fordyce Barker has published a case of membranous

dysmenorrhœa of seven years standing completely cured by iodoform to the interior of the uterus. He first dilated by a sea-tangle tent and then introduced a cone of iodoform every second day to the uterine cavity. This was continued from November to February. In January following the beginning of the treatment she had only a slight amount of pain. In February she had no pain. In March she did not menstruate, and proved to be pregnant for the first time. She had been married six years. Two other successful cases by the same treatment were mentioned by Dr. Barker. These cases are recorded by Dr. B. in the 4th Vol. of the Transactions of the American Gynecological Society.

Dr. Mundé thought that the most inodorous formula is a drachm of iodoform to half a drachm of balsam of Peru and an ounce of glycerine.

Weissenborg recommends the employment of iodoform in the chronic endometritis of chlorotic and scrofulous women, in whom there is reason to fear tuberculosis, cases in which curetting is not advisable. He has devised an instrument to secure the application of a sufficient quantity to the uterine cavity. This consists of a curved syringe of the size of a medium-sized male catheter. The nozzle is provided with two lateral openings. These are filled with the remedy, and when the instrument is introduced to the uterine cavity it is easily deposited therein. No results are given, but further communications are promised. —(*Berlin Klin. Wochenschrift*, 1882, No. 11.)

Dr. J. Mann of Budapest publishes (*Central. f. Gynäkologie*, No. 7, 1882) the results of the use of iodoform at the University Obstetrical Clinic of that city. It was used in 38 cases. At first it was used only to ulcerated surfaces, the result of contusions and lacerations of the passage, the object being to render them aseptic. But soon the remedy was applied to fresh wound surfaces to prevent them becoming septic. The ulcers or wounds are first washed with a two per cent. carbolized water and dried with carbolized cotton. Iodoform in powder is then sprinkled over the surface and retained by iodoform wadding. The iodoform is deodorized by mixing with powdered Tonquin

bean. The author claims the result to be an efficient antiseptic barrier, which permits of the wounds granulating before it is washed away.

Dr. Bayer of Stuttgart (*Central. f. Gynak.*, 1882, No. 10) criticizes Dr. Mann's paper, and recommends in preference salicylic acid and starch, 1 to 5 parts, as a much safer, cheaper, more efficacious, and less objectionable application. The vagina is first carefully washed out with weak Condy's fluid and the remedy then blown in.

Schuking, in a paper, "Ueber Iodoform nachbehandlung und Permanente Irrigation" (*Centralb. f. Gynakol.*, No. 13, 1882), describes his method of treating all gynecological wounds. It consists in washing out the vagina with 1 to 20 carbolic lotion, depositing in it a drachm of iodoform, and washing it out on the third day, after which daily douches are employed. In cases of laparotomy, he rubs the stump and wound surfaces with the drug, leaving in all about one drachm in the peritoneal cavity.

Hospital Reports.

MEDICAL AND SURGICAL CASES OCCURRING IN THE PRACTICE OF THE MONTREAL GENERAL HOSPITAL.

MEDICAL CASES UNDER CARE OF DR. OSLER.

I.—*Cancer of Ascending Colon—Extensive Secondary Growths in Liver.* (Reported by DR. DUNCAN.)

J. R., aged 62, messenger, admitted June 26th with pain in the abdomen, which has continued on and off for about two months, chiefly in the right side. Has been a healthy man. Bowels have been very constipated; no vomiting; appetite good, but he has lost flesh. Pain has been worse at night, and Dr. Blackader, under whose care he was, ordered bismuth and morphia. On admission, patient had a somewhat cachectic look, and the skin is icteroid. Abdomen flattened, and on palpation, there were two specially tender points, one just above the umbilicus and the other in the right lumbar region. In this spot a well-defined tumour could be felt, about midway between the costal margin and the crista ilii. It was tender on firm pressure, im-

moveable, and a clear percussion note was obtained between it and the liver. Right lobe of liver did not appear enlarged, but the left projected considerably below the xyphoid cartilage, and the part was very tender. Hot applications were ordered to the abdomen, and $\frac{1}{8}$ gr. of morphia ter die, and stimulants.

July 7th.—Patient has been losing ground, is more emaciated, and sweats a good deal. Skin still slightly jaundiced. Has a stool each day, copious, soft and clay-coloured. Pain not so severe. Temperature a degree or two above normal. Tumour very evident on right side of abdomen. *10th.*—Has failed rapidly; pulse weak, 108. Enlargement of left lobe of liver more marked, and the tenderness increased. Dr. Ross saw the patient in consultation, and was strongly of the opinion that it was malignant disease of colon, with secondary affection of the liver. On the 12th, abdomen became greatly distended, and there was considerable distress; vomiting became troublesome, and he sank and died on the 13th.

Autopsy.—Body much emaciated. In abdomen, intestines distended and dark-coloured; no peritonitis. Left lobe of liver projected a hand's-breadth below costal border. In right side of cavity was a firm, solid mass, which, after removal of the small bowels, was found to involve the greater part of the ascending colon. The affection began at the valve and extended to within a short distance of the hepatic flexure. When slit open, the whole of the part was a mass of disease, the inner surface in a foul, sloughy state; no narrowing; the calibre of the gut rather increased. The walls were thickened and infiltrated with the new growth. The liver was greatly enlarged, weighed over 6 lbs. The left lobe was nearly the size of the right, and occupied by a huge secondary mass of soft cancer, greyish-red in colour, and very soft. In the right lobe there were four or five masses the size of apples. Fully three-fourths of the organ was involved in the new growth. Nothing special in the other organs.

II.—*Obstinate Quotidian Ague.*

It is not often that such a refractory case of ague comes under observation as the one here recorded.

Lion J , aged 18, a Russian refugee, was admitted on May 31st with chills and fever. Came from a malarious district, but had never suffered before. The attacks began two days ago. Patient is a delicate-looking, anæmic lad. No enlargement of liver or spleen. He complained a good deal of pains in the legs and about the ankles. The attacks came on at first just after noon, and the fever, at its height, usually reached from 104° to 105°. Thus on the 1st, the day after admission, the temperature at 2 p.m. was 105° ; at 8 p.m., 95.5°. He was put upon quin. sulph. grs. v t.i.d. On the 4th, 5th and 6th he was somewhat better, chill only slight, and the highest rise of temperature 101°. Dr. Osler was away until the 11th, and the quinine was continued as above. On the 12th he was ordered a single dose of grs. xxv a couple of hours before the onset of the chill. This was continued for five days without the slightest benefit. Each afternoon the paroxysm came on, and the temperature rose to 105° or 105.5° and sank in the evening to 96°. In the intervals he was up and about the wards. No heart murmur ; no marked splenic enlargement. On the 18th he was ordered ♏ x t.i.d. of Fowler's solution of arsenic. This was continued without any change until the 21st, when the large doses of quinine, grs. xxv, a couple of hours before the chill, and grs. iii t.i.d , were resumed. Not the slightest effect ; every day the temperature reached 105°. On the 26th, ordered eucalyptus, which he took for two days, and then left the Hospital. Dr. G. Tillerie Ross, who attends the Home where these refugees were placed, states that the lad continued to " shake " after leaving the Hospital, and does so still (Aug. 2nd), though the use of ʒi doses of the Fld. Ext. of Eucalyptus appears to be relieving him.

SURGICAL CASES UNDER THE CARE OF DR. RODDICK.*

CASE I.—*Cancer of Tongue—Removal of entire Organ.*

N. W., aged 49, was admitted, giving the following history : Has for years indulged freely in spirituous liquors, and used the ordinary clay pipe, being an inveterate smoker. He has also

* Clinical Clerks—Messrs. Cameron, Bowser, Henry and Nelson.

been in the habit of tasting tea. No history of syphilis or suspicious ulceration of the mucous membrane of the mouth can be obtained. Some years ago he broke the first molar tooth of the right side, leaving a sharp point, which constantly irritated the side of the tongue. About the month of March, 1880, he first noticed a small pimple on the floor of the mouth, under the right border of the tongue; this was cauterized, and apparently disappeared. Some months later, a small indurated mass was felt in the situation of the pimple, and now the decayed tooth was extracted On the 10th September, 1880, Dr. Roddick removed with scissors the nodular mass, together with a portion of the side of the tongue. From this operation the patient appeared to recover perfectly, and did not come under observation again until June 9th of this year.

On admission, the patient appeared in good health; no evidence of cachexia. On examination, a lump of about the size of a pigeon's egg is felt in the vicinity of the original induration, but involving two-thirds of the lateral half of the tongue, and interfering very much with the movements of the latter, preventing its protrusion beyond the line of the teeth. The submaxillary gland of that side is also slightly enlarged.

June 13th.—The patient being etherized, and a ligature passed through the point of the tongue in order to control it, the operator proceeded with scissors to separate the organ from the floor of the mouth, cutting widely; especially on the right side. Nunnelly's incision was then made in the middle line, between the chin and hyoid bone; through this the chain of the écraseur was carried and made to encircle the tongue as far back as possible, being kept in position by means of a long needle transfixing the organ. The entire tongue, with diseased portion, was then readily removed, an interval of a quarter of a minute being made to elapse between each click of the écraseur. The hemorrhage was trifling. As a precautionary measure, a ligature was passed through the stump and held to the cheek by means of adhesive plaster. This was intended to be utilized in the event of hemorrhage or other emergency. The enlarged gland was subsequently removed by means of an incision along the margin of the

jaw. A large drainage tube was passed through the opening, so as to facilitate the removal from the floor of the mouth of saliva and other discharge.

The treatment for some days consisted simply of the application of ice to the stump and the administration of small quantities of milk by means of a spoon. As is usual in these cases, there was at first some difficulty in swallowing, but this became gradually removed. A mouth-wash containing carbolic acid and glycerine was used throughout.

The recovery was uninterrupted, and the patient was discharged cured on the 27th day. He was seen on the 31st July, and could make himself readily understood, although there are many words in which the dentals predominate, which he cannot pronounce. The disease was found, on microscopic examination, to be schirrus cancer.

CASE II.—*Fatty Tumour, involving Biceps Muscle of Right Arm, simulating rupture of the muscle.*

M. F., farmer, aged 68, a healthy, muscular man, was admitted June 2nd, 1882. About three years ago, while in the act of undressing, he first noticed a lump of the size of a walnut on the inner and lower edge of the biceps muscle. As he suffered neither pain nor inconvenience, he paid no attention to it until August last, when he found that he was gradually losing power in the arm. This loss of power increased until he was unable to raise the affected arm above his head without assistance from the sound one. He now began to experience pain both above and below the enlargement, of a gnawing character, and so severe as to deprive him of rest and sleep. The tumour had now reached the dimensions of an ordinary lemon. Exploratory incisions were made on two different occasions, but without reaching the tumour, so that the case was looked upon as one of enlargement of or ruptured muscle.

On admission, a distinct enlargement is noticed involving the inner and lower portion of the biceps muscle. It is moderately firm to the feel, and freely movable when the arm is at rest, but on flexion it becomes hard and immovable ; it is not tender ; the

skin of the affected part is healthy in appearance; the glands are not enlarged, and there are no constitutional symptoms.

June 3rd.—The patient was etherized to-day, and under the spray a free longitudinal incision made over the enlargement. After dividing a rather thick layer of muscular tissue, the tumour was exposed and found embedded in the centre of the belly of the biceps. It was readily enucleated, and found to be purely fatty, some portions being more condensed than others. The edges of the wound in the muscle were brought together with catgut and drained by means of the same material, while the superficial wound was also sutured and dressed antiseptically.

The wound healed rapidly, and the patient was discharged cured on the tenth day. He has since been heard from, and states that he is now free from pain and rapidly regaining power in the arm.

CASE III.—*Stone in Bladder—Lateral Lithotomy—Recovery.*

A. M., aged 14, was admitted May 18th complaining of irregular and painful micturition. His parents are living and healthy, but five children in the family have died of phthisis. There is no history of stone in the family. He has had none of the diseases of childhood, and has always enjoyed fair health, barring the bladder trouble. As long as he can remember, has had frequent and painful micturition, with burning pains in the bladder and along the urethra during and after the act. He further states that he distinctly feels something in his bladder, which changes position with almost every movement of his body; also that frequently during the act of micturition the flow of urine is suddenly arrested. During the past year his urine has been frequently tinged with blood. There is no history of the passage of a renal calculus, but about eighteen months before admission he passed a calculus about the size of a pea during sleep; it was white in colour and crumbled easily. The boy is of average stature for his age, but is anæmic and pasty in appearance.

May 23rd.—A sound was introduced to-day under ether, and the presence of stone readily determined. In one direction it measured one inch and an eighth. It gave the impression of being a soft stone.

May 27th.—The operation of lateral lithotomy was performed to-day, resulting in the extraction of a soft stone, which broke under the forceps. The nucleus, composed of uric acid, was first extracted, and the body (phosphatic) in several large fragments. The bladder was then thoroughly washed out with tepid water. The entire calculus weighed 391 grains.

The patient recovered from the effects of the anæsthetic very slowly, remaining profoundly insensible for more than an hour after the administration had ceased. Hypodermic injections of brandy were resorted to. The hemorrhage was trifling, but the wound became filled with a firm clot, preventing the egress of urine. On this account a gum catheter was introduced through the wound for a few hours. The case went on to recovery without interruption, and the patient was discharged on the twenty-ninth day after operation.

CASE IV.—*Reflex Closure of Jaws—Cure effected with the assistance of Ether.*

Catherine F., aged 20, housemaid, was admitted June 13th, 1882, complaining of inability to open the jaws. It appears that about three months ago she had toothache on the right side, in the last molar. This continued for three days, and on the morning of the fourth she discovered that her jaws were firmly closed. About a week after this they slightly opened spontaneously, and remained opened for about three days, when they again closed, and have remained so ever since, now over two months. During all this time she has been obliged to live on liquid food. The patient is a stout, rather phlegmatic subject, but with no hysterical tendency. The lower jaw cannot be made to separate from the other for more than an eighth of an inch.

June 15th.—Ether was administered to the stage of profound insensibility. The jaws were pulled apart by means of blunt hooks a distance of two inches, and then Smith's gag was introduced. The latter was left *in situ*. She is to be fed on milk alone.

June 16th.—The patient complains of soreness in the teeth and gums from pressure of the gag, but does not direct attention

to the masseters or other muscles of the jaw. The gag was removed and a cork substituted, properly secured.

18*th.*—Much better; all soreness has disappeared. Patient can retain jaws open for an inch and a half, and can close them readily. The cork is retained by the patient herself. To the angles and over the articulations of the jaws an ointment of iodide of potash and belladonna is ordered to be rubbed.

20*th.*—Jaws can be readily, but slowly, opened and closed without pain. She is yet unable to chew any substance firmer than bread, and is warned not to attempt to do so for some time. Asks to be discharged.

The patient was seen four weeks after above date, and found to be suffering no inconvenience, but could masticate almost any ordinary food.

Reviews and Notices of Books.

The Philosophy of Insanity, Crime, and Responsibility.— By Henry Howard, M.R.C.S., Eng. For the last twenty-two years connected with Asylums for the Treatment of the Insane; an ex-President of the Medico-Chirurgical Society of Montreal; author of "Howard on the Anatomy, Physiology and Pathology of the Eye." Montreal: Dawson Brothers.

The subject of the medical jurisprudence of legal criminality has been one to which, especially within the past year, widespread attention has been directed owing to several celebrated cases which have come to trial both in the neighbouring States, in this country, and in Europe. Almost every time that the plea of insanity is raised in a criminal case, we are led to see what diverse views are held by experts upon what constitutes responsibility in the eye of the law. And this will no doubt continue to be so until some more definitely fixed principles shall be laid down, based upon sufficiently scientific data, whereby a true test can be applied. Dr. Henry Howard has been interested in this matter for many years, having been an asylum medical officer, and having taken part in several trials for criminal offences where

the defence was founded upon the prisoner's insanity. The last of these was the trial of Hayvern for the murder of a fellow-prisoner named Salter in our Provincial Penitentiary. Dr. Howard was called by the defence, and gave very strong evidence in favour of the mental unsoundness of the prisoner, urging that the crime was committed through "uncontrollable impulse." In spite of this Hayvern was convicted and executed. A great deal was written in our local journals at the time, both *pro* and *con;* and able reviews of the entire case appeared in some of our American medical papers and in the leading English magazines devoted to affections of the mind and nervous system. It is only right to say that the best of these, in the main points, decidedly supported the arguments of Dr. Howard. The present little work has been put together in order to explain more fully the views held by the author upon this much-vexed question. It is divided into two parts: the first treats of Insanity and Imbecility, especially with relation to the material condition of the brain in these abnormal states; the second deals with Crime and Responsibility, inferences being drawn on this point from the views advanced in the introductory portion of the work. We do not purpose entering upon a criticism of Dr Howard's views. Suffice it to say that they are strongly materialistic, imbecility being looked upon as the result of a teratological defect, and insanity of a pathological defect in some part or structure of the brain. We have found it somewhat difficult to follow the author in his explanations of the supposed pathology—*e.g.*, when he speaks of the possibility of chemical changes in the molecular nerve fluid causing "turbidity of the electric fluid," and of lesion of the sensory nerves rendering "the electric vital fluid turbid or opaque, causing insanity." Some pure hypotheses are startling, *e.g.*, "It requires no very great stretch of our imagination to conceive a germ in the fluid of the different nerves propelled by molecular motion to the organ of consciousness, and while in that organ producing violent mania." On the contrary, we think our imagination must be considerably stretched to admit all this. Some observations are given on the important matter of the temperature in insane persons. The plates of the

brains of Hayvern and Moreau have been reproduced from this Journal. Dr. Howard claims that the result of the examinations of the brains of Guiteau and of Hayvern has shown that both these men were insane. He speaks of this as "an established scientific fact." On the contrary, there is great diversity of opinion even yet upon this very point.

In conclusion, we are given twenty pages from Mr. Serjeant Ballantine's "Experiences of a Barrister's Life," the tales in which make pleasanter reading, but it is difficult to perceive that they are always *à propos*.

Homœopathy, what is it? A Statement and Review of its Doctrines and Practice.—By A. B. Palmer, M.D., LL.D., Professor of Pathology and Practice of Medicine in the College of Medicine and Surgery in the University of Michigan. Second Edition. Detroit: Geo. S. Davis.

This little book is one which it would be well for every one to read. It is absolutely necessary at the present day to know something of the actual standing of the exclusive sect who style themselves Homœopathists, and of the doctrines which they now undertake to teach compared with those of the original founders. All this and much more is brought together here by one who has paid considerable attention to the subject during several years. The writer has visited most of the medical centres in Germany, Austria, Switzerland and France, enquiring as to the standing of the Homœopathic system in those countries. "He has found that nowhere has it any position or recognition in any government institution or in any great hospital or medical school, except in the single case of the University of Pesth, in Hungary."

The doctrines of *similia* and of infinitesimals are somewhat elaborately considered, and from the most modern publications it is shown how far the practitioners of the present day really adhere to or depart from their fundamental principles. The gross absurdity of the so-called "provings," which are still laid down in the therapeutical works of the Homœopathists, is once more pointed out and illustrated by several of the most glaring

examples. It is one of the most wonderful psychological problems how men, otherwise possessed of the ordinary common sense of their fellows, can bring themselves to credit, or think they credit, such arrant nonsense. It is also shown that though Homœopathy has been in existence for more than three-quarters of a century, its adherents can yet not point to one single improvement in science as the result of their labors. One of its own journals speaks of Homœopathy as being here a *humiliated beggar* to Allopathy. "Produce," it says, "produce! Were it but the pitifulest infinitesimal fraction of a product, produce it, in God's name!" "But," says the writer, "this cry, like the calling upon Baal, though like his priests they cut themselves with stones, will be in vain. Men who believe, or pretend to believe, in such doctrines as we have been discussing, will never produce such works as are called for. Never."

Dr Palmer takes strong and, we think, the right ground against association of any kind between regular practitioners and Homœopathists. This subject, of course, is a burning question in the United States just now, owing to the recent action of the New York State Medical Society. He says:—"Every impulse of a legitimate professional pride, every sentiment of fraternal allegiance, every feeling of self-respect, and every principle of honor, impel us to refuse professional associations with such a system and intimate professional and fraternal relations with such men."

We recommend a perusal of this book. It is written fairly, without exaggeration or distortion, and may reasonably be accepted as presenting a picture of the present status of this misleading system of dogmatic errors.

The Physician Himself, and what he should add to the strictly Scientific.—By D. W. Cathell, M.D., late Professor of Pathology in the College of Physicians and Surgeons of Baltimore; ex-President of the Medical and Surgical Society, &c. Baltimore: Cushings & Bailey.

This is an essay on "Personal Questions in Medical Practice."

It is a chatty book, supposed to let the young practitioner into all the secrets which have led to the envied success of those who have gone before him. All sorts of good advice is given him on all sorts of subjects, and we must admit that it contains a great many useful hints—hints which, if taken note of, might prove invaluable to him in after life. The young man fresh from the Hospitals, full of the latest and newest professional and scientific knowledge, and replete with zeal for his patients, is not long, however, in finding out that he lacks many little things which make it difficult for him to avoid troubles with his patients and possibly discord with his *confrères*. Most of these little things, if he be a man of sense and judgment, he finds out for himself, and is able then to escape from. There are a great number of little questions concerning his conduct in a variety of directions which a medical man at the outset of his career would like to have answered for him. We know of no book in which he might look for just such information. It is not a code of ethics he wants so much as the kindly words of a sufficiently shrewd physician of long experience to guide him in the right direction. The author is evidently such an one, and he has taken the trouble to bring all these things together into book-form in the shape of a series of short paragraphs, explanatory and didactic. It is principally intended for those commencing practice, but it will be found both useful and entertaining to all. We confess to having derived both advantage and amusement from its perusal. Perhaps exception could justly be taken to some of Dr. Cathell's views—*e.g.*, he advises the cultivation of æsthetic tastes in the furnishing of one's office, bouquets and flowers being specially mentioned as in order (sunflowers not alluded to), whilst at the same time he considers it "proper and advisable" to display your library, microscope, &c., also your diplomas, certificates of membership, anatomical plates, &c., the human skeleton, either entire or in parts, anatomical specimens and mementos of dissections, &c. To the latter part of this we cannot subscribe, and besides, is there not some inconsistency here? or would really the school of Oscar Wilde approve of skeletons and dried limbs amongst the decorations? Again, "Do not let your office be a

lounging place or a smoking room for horse-jockeys, dog-fanciers, gamesters, swaggerers, politicians, coxcombs and others whose time hangs heavily on their hands." We should hope not. The Doctor is not too hard on the bachelors of the profession; he says, "If you are unmarried, it will often be quoted against you, but the truth is, there is no great professional advantage gained by being married. The objection to most unmarried doctors is really not their being unmarried, but their youthfulness." Regular relaxation and holidays are properly strongly advocated. A caution is given not to adopt the "habit of presenting your photograph to every one enamoured of your professional skill," as it will "cause many awkward dilemmas." Directions are given concerning the views of various religious bodies, on infant baptism, and the duties of the practitioner in connection therewith. "A study of mental therapeutics is one of the necessities that the regular profession is still very deficient in. Remember that Dr. Diet, Dr. Quiet, Dr. Hope and Dr. Faith are four excellent assistants whose aid you should constantly invoke. Dr. Time is also, in some cases, very necessary, but he is slow and unreliable, and unless Dr. Aidwell is called in to assist, occasionally permits a patient to sink into his coffin instead of restoring him."

These are a few points taken quite at random from different pages. They show the gist of the book, which we find almost entirely original. We strongly advise every actual and intending practitioner of medicine or surgery to have the "Physician Himself," and the more it influences his future conduct the better he will be.

Electricity in Surgery.—By John Butler, M.D. Boericke & Tafel, New York and Philadelphia.

It is claimed that very few surgeons indeed could reply, if asked, how much electrical force was needed to accomplish a certain object, whilst an electro-plater, or telegraph mechanic, or an electric light man always knows precisely the quantity of force he requires to employ in any given case. Greater accuracy is certainly to be desired, for, no doubt, success often de-

pends upon the knowledge and experience of the operator of this powerful agent. In a compact little book of little over 100 pages, the author reviews the different surgical disorders in which electricity has proved beneficial. In one of the most important of them all—aneurism—it is stated that the recommendations are entirely derived from other writers, but in most of the others the results given have been obtained from the author's own experience. Though strongly in favor of using electricity more frequently than is commonly done, we do not find that this enthusiasm has led to claiming for it more than is its justly due. A large section is devoted to galvano-causty and its application in surgery. We have no doubt that this treatise will be found useful by surgeons in helping them to greater precision in the use of one valuable means connected with their art.

Books and Pamphlets Received.

Syphilis. By V. Cornil. Translated, with] Notes and Additions, by J. Henry C. Simes, M.D., and J. William White, M.D. Philadelphia: Henry C. Lea's Son & Co.

The Retrospect of Medicine. By W. Braithwaite, M.D. Vol. LXXXV. Jan.-June, 1882. London: Simpkin, Marshall & Co.

The Vest-Pocket Anatomist (founded upon "Gray"). By C. Henri Leonard, A.M., M.D. Detroit: The Illustrated Medical Journal Company.

Transactions of the American Gynecological Society. Vol. VI., for the year 1881. Philadelphia: Henry C. Lea's Son & Co.

La Lithotritie doit etre faite sans Traumatisme. Par le Dr. Reliquet. Paris: Delahaye & Lecrosnier.

What to Do in Cases of Poisoning. By William Murrell, M.D. Detroit: Geo. S. Davis.

Extracts from British and Foreign Journals.

Unless otherwise stated the translations are made specially for this Journal.

The Hypodermic Administration of Amyl-nitrite.—J. J. Frederick Barnes writes as follows to the *British Medical Journal*:—I have administered amyl-nitrite hypodermically thirty or more times during the past eighteen months. In all cases, a ten per cent. solution in rec-

tified spirit was used. In no case did any untoward inflammatory or suppurative symptoms occur afterwards. The action of the drug was immediate in every case, the subjective phenomena being like those experienced when using the ordinary methods of administration. The spirit solution appears to be an excellent preparation for use, as a small quantity kept in an ordinary stoppered bottle for some months retains its full efficiency at the present time. The dose usually administered has been ten minims of the solution, equal to one minim of amyl-nitrite. In lumbago, where the patient is seen at the commencement of the attack, and the disease is not of long standing, the drug given in this manner instantly relieves the symptoms; a patient who is unable, previous to its administration, to bend the trunk without the most exquisite pain, five minutes afterwards can do so quite readily. In a case of paraffin-poisoning, where the patient was in a state of collapse and almost pulseless, one administration (inhalation having been ineffectually tried) brought on an immediate resumption of cardiac function, the man speedily recovering. Its action in this case would, I apprehend, be due to the relief momentarily given to the congested centres by the peripheral hyperæmia induced. In another case, one of duodenal colic, the patient was found rolling on the floor from the acuteness of the pain; when, on injecting fifteen minims of the spirit solution, the pain disappeared as if by magic, and the patient was at once able to resume his ordinary position. The value of this drug by ordinary methods of administration has already abundantly demonstrated how great a boon the discovery of Dr. Lauder Brunton is in the hands of the profession, notably in cardiac angina; and I feel confident that its utility may be still further enhanced by giving it as here recommended, hypodermically.

Some Practical Points in the Treatment of Hemoptysis.—Dr. James M. Williamson, of Ventnor, writes on this subject to *British Medical Journal*:— Constipation must not go unrelieved, and is best treated by salines. A quick pulse must be steadied by digitalis, of which

perhaps the most handy form is the digitaline granule of Homolle and Quevenne. Cough is to be soothed, the simpler the mode of accomplishing this the better, but it must be done; and nothing answers better for this than a chloroform pad laid over the sternum. Speaking in a general way, and not alluding to hemoptysis of cardiac origin, I hold that we should keep before our minds the advisability of stopping all blood-spitting in phthisis without delay. To this rule, perhaps, there are two exceptions. The first is trivial. It is that dirty-red, slimy, bad-smelling, never abundant expectoration which hysterical women with phthisis often exhibit at the bottom of their spittoons; this may be left to itself. The other exception is a serious one; it comprises those forms of hemoptysis, usually copious and angry, occurring in advanced and very chronic cases where there is a considerable amount of fibroid induration. In such patients, notable dyspnœa or exertion has for a long time been a prominent symptom, and respiration has been maintained by a very small extent of lung-substance. These cases are open to a special danger, that of fatal embolism in the right chambers of the heart or the pulmonary artery. Not uncommonly the course followed is for the bleeding gradually to abate in quantity, remaining, nevertheless, of the same angry red; then urgent dyspnœa suddenly sets in, and death takes place within forty-eight hours. These are cases calling for extremely careful treatment. Can it be right, where only a small surface is available for respiratory function, to contract those few vessels with ergot? Or can it be good practice to pass styptic medicines into a patient's circulation when his cachectic state, his low vitality, and perhaps some febrile movement, render him specially liable to the formation of thrombi? It is wisest to limit ourselves to external applications, chloroform pads, dry cupping, sinapisms at a distance, or other derivative treatment, with appropriate general management. Perhaps I may be allowed to conclude with two cautions, common-place they may seem, but both of them the outcome of bedside experience. One is, to have some responsible person in attendance night and day, on all cases of severe bleeding, till the attack has com-

pletely passed away. Death in hemoptysis is generally sudden, and it is very appalling to discover too late the consequences of omitting this precaution. The other is, to decline positively to examine a patient's chest while there is any hemoptysis. Irrespectively of the danger of the process, an opinion arrived at by auscultating a chest during or immediately after a bleeding is not a reliable one.

Successful Reduction, after Four Months' Malposition, of a Dislocated Third Cervical Vertebra, Causing Various Serious Nervous Symptoms.—Dr. Landon Carter Gray, of Brooklyn (*Annals of Anatomy and Surgery*), says :—A lad, fifteen years old, was brought to me. Four months before he had attempted to turn a somersault, and had fallen upon his head. There was neither loss of consciousness at the time nor any untoward symptom other than the appearance of a small projection upon the back of the neck. The next morning he experienced some slight difficulty in swallowing, which steadily increased, although varying in degree from day to day. About thirteen weeks after the accident the bladder became distinctly, though not markedly, paretic. About fourteen weeks after, the patient became sensible of a numbness in the left arm. Three days before coming to me, the left upper and lower extremities became powerless, although, singular to say, this lower extremity had not shown any subjective alteration of sensation except a slight itchiness. During the week previous to his visit a slight numbness had appeared in the right leg. At this first examination I found the left upper extremity almost completely paralyzed in motion, the left lower extremity somewhat less so, both these extremities moderately paralyzed in the sense of touch, and the left side of the face paretic. The left upper extremity was decidedly fuller than the other, without, however, presenting any œdema or unusual vascularity. There was occasionally a quick, sharp tremor of the whole body, which came on only while he was standing. The tendon reflex of each quadriceps extensor was greatly exaggerated ; but there had not been at any time any symptoms of

hasty micturition. Over the region of the third cervical vertebra there was, on the back of the neck, a projection about as large as a pigeon's egg. Pressure upon it produced some pain around the point of pressure, but none was felt at the front or side of the neck. The spinous process of the third cervical vertebra was deviated markedly to the right. Inserting the finger into the mouth, horizontally backward on a level with the upper surface of the tongue, a distinct depression could be felt in the posterior pharyngeal wall, corresponding to the third cervical vertebra. The attitude of the head was peculiar. The right ear was strongly inclined to the right, the chin directed to the left, but the point of the chin was not elevated. The right sterno-cleido-mastoid was prominent and tense. The point of the left shoulder was drawn up, the acromion process of the scapula being approximated to the median line of the body, and the inferior angle being thus thrown out. The difficulty of swallowing had become so great that the boy was fed on soft and liquid food, and at certain times even this was troublesome; the nervous symptoms were progressing at an ominous pace; nothing but a restoration of the bone to its proper place offered any hope of saving life; and if the reduction were prevented by the callus of a former fracture of the spinous process, no harm could be done by the attempt. In making reduction counter-extension was made by means of folded sheets laid over each shoulder and then brought across the back and shoulder to the opposite side, where the ends of each were placed in charge of an assistant. A gag was used to separate the jaws. The boy was laid flat upon his back on the table, and etherized until all his muscles were well relaxed. Supporting the head by one hand upon the occiput and the other upon the brow, both my hands being covered by those of an assistant, and counter-extension being firmly maintained, I made extension steadily upward to what I deemed a proper degree, and then slowly and cautiously rotated the head from left to right. It was necessary to make this rotatiou three several times before the bone went into place, each rotation, however, effecting evident improvement, althoug no tendinous snap was heard at any time. On

returning to the house about four hours after the reduction I was gratified at finding the boy bright and cheerful, having no longer any difficulty in deglutition,—he had drunk heartily of milk, which he had hitherto taken only by the spoonful—able to lift his hand readily to the top of the head, much improved in motor control of the left lower extremity, and free from numbness anywhere. The patient was not permitted to rise from the table for upwards of three weeks. During this period the head was kept between the prongs of a photographer's head-rest, which permitted of sufficient lateral motion to render the position endurable, and at night a watch was kept to see that the head was not displaced from this support. At the end of this time he was allowed to assume a sitting posture for a couple of days, and then to go about the room. I now noticed that the spinous process of the third cervical vertebra began to deviate again from the line of its fellows, but only to a very slight degree, and a faint depression could again be felt corresponding to the vertebral body; no nervous symptoms, however, were manifested. I was reluctant to interfere again unless it became absolutely necessary, and I contented myself with enjoining great caution and deliberation in the movements, as well as confinement to the house. Notwithstanding these directions, the patient, after a week of this irksome life, started out one morning and walked for several hours. The next day I found a distinct, though not very marked, displacement of the vertebra. I immediately determined to run no risk of pressure upon the cord, and accordingly brought the table and the photographer's head-rest into play as before, and kept him thus until I again reduced the bone a few days after. The reduction was easily made, and the bone went into place with a sharp ligamentous snap. Two weeks more in the supine posture and the patient got up, cautiously at first, and has had no further trouble.—*American Medical Weekly.*

Improved Pharmacy.—The fact is not new, but it has been quite recently made more prominent by Sidney Ringer in his Handbook of Therapeutics, that small doses of

medicine frequently repeated act more efficiently than large doses given at longer intervals. Bartholow, Petero, Desau, and many others also recommend the use of minimum doses in almost every variety of disease. My attention was first called to this subject by my friend and former partner, Dr. J. B. Cook, and by observation and actual experience I have so convinced myself of their efficacy that, with one or two exceptions, I have discarded the larger doses, and by doing so have, I am sorry to say, been charged with practicing homœopathy. The believers in medicine and their efficacy in treating disease do not appear to increase. On the contrary, it is rather refreshing to meet with a practitioner now-a-days with any reliance on drugs. I would say to these doubters, try the small doses often repeated and your faith will revive. Take the first child you have in your practice with catarrhal fever or croup, and give it fourth or half-drop doses of aconite in a teaspoonful of water, repeated every ten or fifteen minutes, and you will see the fever driven off and disappear like frost before the summer sun. But there is an advance yet to be made and a point reached when we shall exclude all save the active principle of drugs. Quinine is far preferable to the bark, morphia to opium, and why should not the alkaloids and their salts, aconitin, veratrin, hyoscyamine, strychnine, digitalin, ergotin, and others given in small doses ($\frac{1}{120}$ or $\frac{1}{60}$ grain of the more potent) at short intervals—every quarter or half hour or hour—and discontinued or given at longer intervals when relief is afforded, be far preferable to the large and oftentimes nauseating compounds which are so frequently prescribed? The thanks of the profession are due and should be extended to advanced pharmacy for rendering it possible to administer medicines in forms which are not only accurate and reliable, but in many instances pleasant to the eye and to the taste of both children and adults. We cannot afford to allow a blind and foolish prejudice against what is called homœopathy to prevent our welcoming any advance which may tend to remove skepticism and restore faith in our healing art, and at the same time render our remedies palatable and pleasing alike to the taste and to the eye. A writer in a recent number

of *The Lancet* says, "No man who has ever used aconitine for the reduction of temperature will hark back to the tincture, Fleming's though it be, or any crude form of the drug; and he who has not used hyoscyamine in trouble of the hollow viscera —stomach, bowels, bladder, etc.—has yet to experience the satisfaction and joy with which he will be greeted after prescribing it for a patient with spasm, retention, dysentery, or hernia; for this last is often spared the surgeon's knife by this beneficent drug." The wise physician is he who has learned to choose the quickest and the best remedy for the relief of his patient, unmisled by superficial differences; who can shun the rocks where others have been wrecked, or from foresight of what is coming can be cool when the peril is upon him.—*Dr. Dixon in Louisville Med. News.*

Aconite in Acute Dysentery.—Dr. W. Owen, Port Blair, India (*Indian Medical Gazette*, April 1, 1882), reports having treated 157 typical cases of acute dysentery with aconite. He was induced to give aconite by the following considerations:—First. Its influence in other acute inflammations. Second. From its relieving internal congestion. Third. It has a marked antipyretic action in febrile cases. Fourth. It has a sedative action on the gastro-intestinal mucous membrane. He gives one minim of the tincture of aconite (British Pharmacopœia) every quarter of an hour for the first two hours, and a minim an hour subsequently, making half a drachm in twenty-four hours. This method has been found by him to be followed by the very best results in the great majority of his cases.—*Chicago Medical Review.*

External Hemorrhoids.—Dr. Pasqua, of Florence, gives the following ointment as infallible:—

Ext. Belladonna, - - - - - -	gr. vss; 0.33 Gm.
Iodoform, - - - - - - - - - -	āā gr. j; 0-06 Gm.
Acetate of Lead, - - - - - -	
Petroleum jelly, - - - - - -	5j; 4.00 Gm.

Make into an ointment, to be applied three or four times a day. —*Druggist's Clerk.*

Corrugated Paper as a Splint.—Dr. Walter Pye gives an account (*British Medical Journal*) of a new splint, which he has found of great value. Its most important feature is flexibility combined with stiffness. It is made of a material known as corrugated paper, and is very cheap and light. Dr. Pye says:—"From the purely surgical point of view, I have found this corrugated paper extremely useful. It can be used in all cases in which the expensive kettle-holding splinting has been employed, and makes about the best angular splint for the elbow I have ever seen. The commercial use to which this paper is put is either that of packing wine bottles in cases, or else of enabling single bottles to be wrapped in a parcel not indicating its contents." The corrugated paper thus used in surgery by Dr. Pye is of American invention.

Aborting Syphilis.—Some time ago Gantier found that if an intra-venous inoculation of rabietic virus was made upon sheep, this prevented a second hypodermic vaccination from having effect. Hubert (Lyon Mèdicale) claims that something of this kind occurs where a mother secures immunity from syphilis by carrying a syphilitic child, the virus affecting the mother through the blood. He believes that if intra-venous inoculation were done with the secretion and blood of the initial chancre, that systematic infection might be aborted.—*Chicago Medical Review.*

Rheumatism and Syphilis.—Dr. B. C. Lockwood (*British Medical Journal*) has noticed that the prior existence of rheumatism exerts a marked influence on the initial lesion of syphilis, causing it to take on a phagadænic and necrotic character. He believes that this explains the occurrence of many cases of malignant chancre which are from time to time reported by syphilographers. He is inclined to think that in these cases mercury does harm, and that potassium iodide is of very great benefit. His cases certainly appear to indicate that the relationship between the rheumatism and the malignant chancre is more than coincidental, but require further confirmation.—*Chicago Medical Review.*

CANADA

Medical and Surgical Journal.

MONTREAL, AUGUST, 1882.

OUR EDITORS.

A change has been made in the editorial department of this Journal. Dr. Molson, who has for the last three years been associated with Dr. Ross in the work, has been compelled to resign owing to other engagements. We are, however, pleased to be able to say that we have instead obtained the co-operation of Dr. Roddick, the Professor of Clinical Surgery in McGill University. This announcement, we are sure, will meet the approval of all our readers, as the Doctor's energy and literary ability are both sufficiently well known. Since the present senior editor has had charge of the publication, considerable improvements have been made in several of the departments, and, as will be remembered, the size has been increased from 48 to 64 pages. A special series of *resumés* has been established and regularly carried on, viz., on Surgery, by Dr. Shepherd; on Gynecology, by Dr. Gardner; and on Therapeutics, by Dr. Stewart. We are satisfied that these have been much appreciated by our readers, and a further tribute to their excellence is afforded by the frequency with which they have been drawn upon by our exchanges. Our original pages have, we think, been fairly well filled, and several papers of more than common interest and on subjects of great professional importance have first appeared here. We are thus indebted to many of our friends for valuable contributions, and we hope to receive at their hands many similar favors. We think that a good many, especially of our younger graduates, do not yet quite appreciate the importance to themselves of writing for the medical journals. There is no way in which a

well educated medical man can so improve himself, and at the same time enhance his own reputation, as by frequently preparing communications for his local journals. Reports of our Canada association and of our local societies have been made as full as posssible, and appear as promptly as possible. In conclusion, it is a matter of great satisfaction to find that our efforts at improving the JOURNAL and maintaining the character it has always held have met with their reward, for our circulation is steadily increasing and we now reach many more readers than ever before.

Under the present management every effort will be made to sustain the different departments of the JOURNAL, to remedy any deficiencies which may have been observed, and to maintain it as heretofore in every respect a first class medical periodical.

COUNTER-PRESCRIBING.

The following account of a most glaring and inexcusable instance of interference with a physician's prescription by a druggist is taken from the *Canadian Pharmaceutical Journal*:—

"Mr. George Mortimer, the defendant, is an old and respected druggist, doing business on York street, Ottawa, in which city he has resided for the past twenty-six years. He holds certificates from the Ontario and Quebec Colleges, and some thirty-five years ago learned his business in Aberdeen, Scotland. On the first of July last, a young man named Thomas Mulrooney called at Mr. Mortimer's shop and presented a prescription from Dr. Cranston, of Arnprior, but, instead of dispensing it, Mr. Mortimer informed the patient that he could give him something better, and on the strength of this statement sold him a preparation of his own. For this he was summoned to appear before the Police Magistrate, on a charge of giving medical advice without being a licentiate of any medical college. Mr. Mortimer, in defence, said that what he sold was a specialty; that he had given the advice entirely gratis, as, he claimed, anyone had a right to do; and that he had done the same thing for thirty-five years past, and that he only did what every druggist in the Dominion was in the habit of doing. The Magistrate de-

cided that the law had been broken, and imposed the lowest fine allowable—$20 and $2 costs. Mr. Mortimer gave notice of appeal, but, on further consideration, has given up the idea; but in conversation with a *Globe* reporter he expressed the opinion 'that the druggists of Ontario should combine together for the purpose of getting the law modified, it being certain that, with proper representation, this could be done.' So far the case is without complication, and it is an easy matter to form an opinion as to its merits. Although we are the mouthpiece of the druggists of Ontario, and are sorry to say a word adverse to the interests of any member of the College, in this particular instance we must confess that we believe the Magistrate's decision was alike in accordance with law, justice and common sense. Mr. Mortimer decidedly overstepped his position as druggist, and had no right whatever to substitute any preparation for that named in the prescription, no matter what his opinion of the merits of the medicine might have been. When, as a tradesman, he sold a preparation of his own, it may be presumed that he disposed of the goods that yield him the most profit, and this renders the case even stronger against him. We feel sure that we express the feelings of the drug trade in condemning this unwarrantable interference and in commending the verdict." The *Journal* clearly states the position which should be maintained by every pharmacist who desires to see his profession holding the high position it is entitled to, and ought to be supported in, by medical practitioners everywhere. The best interests of both pharmacists and physicians are subserved by both adhering strictly to the limits of their respective fields of usefulness. Those druggists who are addicted to the evil practice of surreptitious counter-prescribing are the worst enemies of their class, and we are pleased to find our contemporary actively interested in doing what it can to educate the fraternity to see that, in so doing, they are operating directly against the common good. We are willing to believe that such instances as the above are sufficiently uncommon in this country, and that the publicity given to this case, and the interest it has excited in Ontario, will prove of service in still further diminishing their frequency.

BIDDING FOR STUDENTS.

The following from the New York *Medical Gazette* shows forcibly the loose manner in which, in that free country, teaching and collegiate powers may be assumed by almost any man no matter how illiterate or unfit. We suppose many of our friends in "canady" have received invitations from Dean Petit to send students to Joplin, Mo., for their education—the inducements being very short terms and very small fees:—

COLLEGE OF PHYSICIANS AND SURGEONS,
JOPLIN, MO., 5, 18, 1882.

GENTS.—Please send *price list* of *Doctors* and *Druggists Names* by States as I want to mail *several thousand* Annual *Catalogues* to the *Profession*, all over the U.S.A. and canady. I am starting an embriotic-Pioneer-Medical College and I must, of necessity, noise it around to the world to make it pay me. An early reply will greatly oblige your Respectfuly, &c.,

J. C. PETIT, M.D., Dean.

"The above monument of epistolary art, and record of the aspiring plans of a would-be medical teacher was recently received by the publishers of the *Gazette*. Its unique orthography, displaying, as it does, the untutored mind of the author, untrammeled by the shackles of education, is a silent rebuke to the indifference of a public and profession which permits men of this stamp to usurp the functions of teachers, and teachers, of all arts, all sciences the most exacting, medicine. It is refreshing to see the simplicity with which this would-be Dean unconsciously defines the purpose of his "*embriotic pioneer Medical College*," namely, "to make it pay me." At what expense to good medical instruction, to the interests of his profession, or of humanity, his purpose will be accomplished probably has not occurred to him. But why rail at an individual instance of an evil that is above all else the stumbling-block to good medical instruction, namely, the necessity which makes financial success the condition of existence for our medical colleges. As long as this is so, shall not our most conscientious teachers be obliged to cater to the tastes of their patrons, the students, both in regard to the character and duration of the instruction. What stronger argument for endowed institutions and their independent instruction can

be furnished than this alarming growth of so-called colleges, which are most often, as in this case, business enterprises, money-making schemes, engineered by some ambitious but illiterate and unscrupulous person."

MEDICAL FACULTY, WESTERN UNIVERSITY, LONDON, ONT.

The organization of this Faculty opens a new Medical School for our Canadian youth. London is a thriving young city of 20,000 inhabitants, situated in the best district of the Dominion, and was fortunate enough, a few years ago, chiefly through the exertions of Bishop Hellmuth, to obtain University powers for a local college. Certain members of the profession in the city have been found willing to undertake the arduous duties of a Medical Faculty. We trust they have obtained a full share of the University funds for the purpose, or are prepared to dive deep into their own pockets. From what we remember of the amount of the original endowment, the entire sum would be about what a medical school should start with It is only due to the profession, to which the schools are nurseries, that the teaching bodies should be fully equipped with modern appliances. We look forward hopefully to the time when *all* the theological seminaries in *all* the Provinces have *all* the money they need—then the non-sectarian colleges and the medical schools will begin to get satisfactory endowments, and then only, so far as the latter are concerned, will they be on a satisfactory educational basis. The success of this new school is in the hands of the men connected with it. If they are active and energetic, thoroughly in earnest, zealous in their respective departments, a good share of professional patronage will fall to them. The only serious obstacle we can see to ultimate success is deficient hospital accommodation. It will be a long time before London needs a hospital of 100 beds—the number, by the way, fixed for recognition of tickets by the Ontario Council and the various licencing boards of Great Britain. The Faculty seems to have been judiciously chosen; one arrangement strikes us as particularly good. Mr. W. Saunders—perhaps the ablest pharmacist in Canada, and

one of our leading scientific men—lectures on Materia Medica, while Therapeutics is dealt with from a separate chair. The *personnel* of this school is as follows:

Chas. G. Moore, M.C.P.S., L.C., Principles and Practice of Surgery, Dean of the Faculty; John M. Fraser, B.A., M.D., M.R.C.S., Eng., Principles and Practice of Medicine; R. M. Bucke, M.D., F.R.S.C., Nervous and Mental Diseases; Wm. Saunders, F.R.S.C., Materia Medica and Pharmacy; J. A. Stevenson, M.D., Therapeutics and Toxicology; James Bowman, Theoretical and Practical Chemistry; Charles S. Moore, M.D., C.M., Obstetrics and Diseases of Women and Children; F. R. Eccles, M.D., M.R.C.S., Eng., F.R.C.S., Edin., Physiology; Wm. Waugh, M.D., C.M., Anatomy, General, Descriptive, and Surgical; H. Arnott, M.B., Clinical Medicine; James Niven, M.B., M.R.C.S., L., Clinical Surgery; W. H. Moorhouse, M.D., L.R.C.S., and L.R.C.P., Edin., Histology and Dermatology; G. P. Jones, M.D., Sanitary Science; Alex. G. Fenwick, M.D., M.R.C.S., Eng., Medical Jurisprudence; John Wishart, M.D., M.R.C.S., Eng., F.R.C.S., Edin., Demonstrator of Anatomy. Secretary-Treasurer, J. A. Stevenson, M.D.

REPORT OF ROYAL COMMISSION ON THE MEDICAL ACTS.

The report of this important body is published in the current numbers of the London weeklies. The essential feature is expressed in the following extract: "They propose, in general terms, that there shall be one Medical Council, and that, in each of the three divisions of the United Kingdom, there shall be a Divisional Board, representing all the medical authorities of the division; that the right of admitting to the *Medical Register* and a general control over the proceedings of the Divisional Boards shall vest in the Medical Council; and that, subject to such control, each Divisional Board shall, in its own division, conduct the examinations for licence." The condition will be very similar to what prevails in Ontario, and will, we feel certain, if adopted, give satisfaction. The corporations will feel it hard to have the licensing power taken away, but many of them richly

deserve to have their candlesticks removed. A point of interest to us is the position taken with regard to Colonial graduates. The Commission virtually recommends the proposal of the Government Act of 1880, which provides that persons with colonial diplomas may register without further examination as *colonial practitioners* in the Medical Register. This is quite as much as we want or should ask, considering that the Medical Council cannot possibly supervise the colonial examinations of the 18 members of the Council. It is recommended that four be elected by the registered members of the profession in Great Britain. For this the profession has to thank the British Medical Association, which has for years advocated direct representation.

College of Physicians and Surgeons of Chicago.—The announcement of this new Institution is to hand. It has been organized—like all others—"in the interests of a more thorough and practical education than is usually furnished by the medical schools of this country." We had hoped that from the outset this new college would have demanded three full sessions of six months, and so set a good example to Western Schools. But no; it is a private monetary enterprise, and must be put on a paying basis, and for this the profession must be sacrificed to the demands of impecunious and ignorant students who seek the quickest, cheapest and easiest course to the degree. The board of directors has erected a magnificent building opposite the large Cook County Hospital. Judging from the woodcut and the description, it must be one of the best equipped schools in the country. We are glad to see the name of our old friend, Leonard St John, M.D., (McGill, '72) on the board of directors and Professor of Demonstrations of Surgery.

Canada Medical Association.—The annual meeting of this Society will be held in the City Hall, Toronto, on the 6th and 7th September, under the Presidency of Dr. Fenwick. The local committee have been at work, and the prospects are good for a large and interesting gathering. The usual arrangements for reduced rates will be made with the railways, and certificates

will be issued on application to the General Secretary, Dr. Osler, Montreal, or to the Local Secretaries, Dr. H. Wright, Toronto, Dr. Belleau, Quebec, Dr. C. D. Rigby, Halifax, and Dr. C. Holden, St. John. Gentlemen wishing to read papers are requested to send the titles to the General Secretary at as early a date as possible.

Semi-Centennial Celebration of McGill Medical Faculty.—The Acting Dean has issued the following circular to every graduate whose address is known :—

Medical Faculty, McGill College,
Montreal, June 27th, 1882.

Dear Sir,—In October next the Medical Faculty of McGill University will enter upon its Fiftieth Session. We feel that the occasion is one which should not be allowed to pass unnoticed, and arrangements are being made to celebrate the event in an appropriate manner. We trust that you will be able to be present on this occasion. Due notice will be given and a formal invitation sent to you. This preliminary circular is simply for the purpose of announcing the fact, that you may make your arrangements with reference thereto.

Yours truly,
On behalf of the Faculty,
R. P. HOWARD, *Acting Dean.*

Canadians at the College of Surgeons, England.—The *Lancet* for the 27th ultimo contains the report of the Board and Court of Examiners of the number of candidates who presented themselves during the collegiate year 1881-'82, and the number who have passed and have been rejected from each school. We gather from it that ten Canadians presented themselves for the Primary—of these 7.50 passed : six went up for the Pass, and 4.50 were successful. The fraction indicates that the candidates received their education at more than one school. The percentage of rejections appears to be somewhat less among colonial candidates generally than among the British students, and so it should be, as the former, as a rule, have already taken degrees and followed their studies for four years.

New Brunswick Medical Society.—The annual meeting of this Society was held at St. John, N.B., on the 18th ultimo.

The President, Dr. Steeves, delivered an address upon Insanity containing much that was of interest and founded upon his own observations. Papers were read by Drs. Margrove, Coleman, Gray, Allison and Atherton, and several matters were discussed having in view the advancement of the profession in the Province of New Brunswick. The members inspected the General Public Hospital and the Lunatic Asylum. The meeting was in every way a successful one.

Drainage—Contamination.—A great outcry has come from the inhabitants of Longue Pointe, a village about five miles below this city. Sickness has been very rife there of late, enteric complaints chiefly prevailing. The water is said to be the main cause of this trouble. It is all obtained from the river, and strangers drinking of it are at once very badly affected. The drain from the Longue Pointe Asylum opens into the river directly at this spot, and it is reputed to be in a very bad sanitary condition. Some repairs are now being done, but the inhabitants would act very wisely if they compelled the authorities to lead their sewage somewhat lower down so as to escape the village.

The Smallpox Hospital.—The Board of Health have decided to remove the Smallpox Hospital from its present site in the Park to some other less conspicuous locality. It is satisfactory to know that it has been without patients for a length of time, although a small staff has been maintained to provide for any possible outbreak of the disease. The great difficulty now seems to be to find any place for it as, naturally, each municipality strenuously objects to harboring such an edifice. The latest idea is to give it a corner in one of the cemeteries. This might have its advantages, but the outlook would hardly be that best calculated to raise the spirits of the survivors.

Belmont Retreat.—We have received a circular from Mr. G. Wakeham, the proprietor of the well known Belmont Retreat,—a private establishment for the cure of insane persons and inebriates—stating that he is desirous of either securing a part-

ner or else selling out. This is an opportunity which might be availed of by some young medical man with a little capital, and who has had some experience in this direction.

The New City Hospital, Hamilton.—We had the pleasure of a visit to this fine building a few weeks ago, which is almost ready for the reception of patients. The formal opening will take place shortly, and we will then have an opportunity of giving a detailed description of the building

Old Authors.—Dr. Oliver Wendell Holmes, in a recent address, alludes to the good things to be got by our going back to some of the older and now neglected authors. He says: "Would you know how to recognize 'male hysteria' and to treat it, take down your Sydenham. Would you read the experience of a physician who was himself the subject of asthma, and who, notwithstanding that, in the words of Dr. Johnson, "panted on till ninety," you will find it in the venerable treatise of Sir John Floyer. Would you listen to the story of the king's evil cured by the royal touch, as told by the famous chirurgeon who fully believed in it, go to Wiseman. Would you get at first hand the description of the spinal disease which long bore his name, do not be startled if I tell you to go to Pott—to Percival Pott, the great surgeon of the last century."

—We have received a copy of the second annual report of the astronomer in charge of the Horological and Thermometric Bureaus in the Observatory of Yale College, by Leonardo Waldo. It contains a number of interesting statements concerning their work with reference to the correction of physicians' clinical thermometers. During the year, 3811 thermometers have been examined and returned to the owners with certificates. It is found that considerable improvement is being made in the manufacture of clinical instruments in the United States. Experiments have been made with a view of discovering some ready test by which one could estimate, with any particular instrument, the time required for obtaining the maximum reading; but this has not yet been obtained. The variations in

time are mostly due to the varying thickness of the glass forming the bulb, and the shape in which the latter is moulded.

Obituary.

Prof. Balfour, of Cambridge.—By an unfortunate accident in the Alps this distinguished investigator has lost his life, and the University, which had so recently established for him a Chair of Morphology, mourns over an unusually brilliant son. Though a very young man Mr. Balfour had done exceptionally good work, and his two volumes of Comparative Embryology will secure him a lasting reputation. He was one of a band of earnest workers which Professor Michael Foster has gathered about him at Cambridge, and in a touching notice in the *British Medical Journal* Dr. Foster places on record a fine estimate of his life and work.

Dr. Alexander Greenlees, of Toronto, died on the 10th. He graduated at Toronto University in 1870. Entering upon practice in Toronto he soon acquired a large *clientele*. For several years he lectured upon Practical Chemistry in the Toronto School of Medicine.

Personal.

Dr. Robert Wight, of St. Johns, Que., died on the 28th ult., aged 69.

Hugh Gale, M.D. (McGill, '82), has begun practice at Bad Axe, Michigan.

Alexander Shaw, M.D. (McGill, '82), has begun practice at Bancroft, Michigan.

Robt. C. Blair, M.D. (McGill, 1865), has moved from Chicoutimi to Three Rivers.

Dr. John Chiene has been appointed to the Chair of Surgery in the University of Edinburgh, in the place of the late Prof. Spence.

Napoléon Chevalier, M.D. (McGill, 1873), late of Iberville, Que., is at Lewiston, Me.

V. G. B. Chagnon, M.D. (McGill, 1861), late of St. Pie, Que., is at Fall River, Mass.

Dr. O. C. Edwards, who left this city for Qu'Appelle a short time ago, gives a glowing account of the district.

B. W. Burland, M.D. (McGill, '82), has begun practice at Mineville, N.Y.

John G. Kittson, M.D. (McGill, '69), formerly Surgeon to the N.W. Mounted Police, has begun practice at St. Paul, Minn.

Walter J. McInnes, M.D. (McGill, 1865), whose address in the last college commencement is given as East Saginaw, Mich., is practicing at Vittoria, Ont.

R. J. B. Howard, B.A., M.D. (McGill, '82), passed the M.R.C.S., Eng., on the 31st ult. Reuben Levi, M.D. (McGill, '76), passed the Primary of the same College. H. W. Thornton, B.H., M.D. (McGill, '82), and R. J. B. Howard, passed the L.R.C.P., Lond., on the 27th ult.

A medical friend writes from Winnipeg that "the city is in a beastly healthy state at present, and any number of medicos here." Another, an assistant surgeon on one of the sections of the C.P.R., gives an accout of pretty rough life looking after the men in the different camps.

Dr. Silver, for many years intimately associated with the editorial department of the *Medical Times and Gazette*, died on the 16th ult., aged 41. He is best known as the editor of Hooper's *Vade Mecum*, and as the author of a small work on "Practice of Medicine. He was a physician to Charing Cross Hospital, and a very popular teacher in the school.

The Registrar of the Medical Faculty sends the following corrections:—In the recently issued announcement the name of John R. Church should appear in the list of those who passed the Primary. In the list of Prize-men and Medallists the names

of J. M. Lefebvre, of Brockville, Sutherland Gold Medallist, 1878, and W. L. Gray, of Pembroke, Sutherland Gold Medallist, 1879, were accidentally omitted.

Medical Items.

British Medical Association.—The fifteenth annual meeting was held at Worcester on the 8th, 9th, 10th and 11th inst.

Four Years' Course in the United States.—At the recent commencement at Harvard University—28th June last—nine men graduated after a four years' course, whereas seventy-seven graduated at only three years. This is the first time that the longer course has ever been followed in any American college.

—The *London Gazette* of the 19th June announces that the Queen has been pleased to appoint T. Grainger Stewart, Esq., M.D., Professor of the Practice of Physic in the University of Edinburgh, to be one of Her Majesty's Physicians in Ordinary for Scotland, in the room of Sir Robert Christison, Bart., deceased.

—The new antiseptic, boro-glyceride, has been successfully used by Mr. Richard Barwell as an antiseptic in surgery. He places a few folds of lint soaked in the solution upon the wound. It is unirritating, and healing takes place in a perfect manner. The dressing is exceedingly simple.

—Carelessness at judicial autopsies is notoriously frequent in the United States (and perhaps here also). Insufficient remuneration is sometimes given as the cause. In a recent case, where the witness could not testify upon an important point and was asked the reason, he replied that "the authorities were only willing to pay for a dollar *post-mortem*, and he had given them only a dollar one."

A Mistaken Diagnosis.—A case of sickness occurred twelve miles from Fort Worth, Texas. A country physician in attendance was asked if the case was not one of smallpox. He,

in reply, stated no; that the case was one of extraordinary interest, and without parallel in his whole reading or personal experience. Further, that he would wager that, should Dr. A., B. or C. be called from Fort Worth they would corroborate his diagnosis, which was that the man had "erysipelas from the toes to the knees, measles from the knees to the waist, and seven years' itch from the waist to the top of the head." An intelligent physician being called in readily diagnosed confluent smallpox.

—Dr. Payne, in the *North Carolina Medical Journal*, strongly condemns kissing, from its liability to propagate disease, and cites the case of a young man in the secondary stage of syphilis conveying the disease by kissing to a child sixteen months old, the child in turn giving it to the mother.

—Dr. O. W. Holmes says he has known a practitioner—perhaps more than one—who was as much under the dormant influence of the last article he has read in his favorite medical journal as a milliner is under the sway of the last fashion plate. The difference between green and seasoned knowledge is very great, and such practitioners never hold long enough to any of their knowledge to have it get seasoned.—*Atlanta Medical Register.*

One Cow's Milk.—A child fed on one cow's milk recently died of tuberculosis, and the cow died a few months later of tubercular disease. If the milk of several healthy cows had been mixed with this one cow's milk, the results might have been different. See to the condition of the cow before selecting its milk for your babe.

Treatment of Tympanitis.—In Dr. Nicolas Culpepper's Astrological Judgment of Diseases (London, 1671), the following case is recorded: "I care not greatly if I relate the cure done in such a case by one of the wisest Physitians that ever the Sun shon upon in England, Dr. Butler of Cambridge. A gentleman was possessed with Wind in his belly; a great inflammation there was there. The Doctor comes to him, and perceiving the

original of it was wind, for he was a man of penetrating judgement, calling for a Rolling-pin; The man was never subject to covetousness, and as little to pride; Down turns he the Cloaths from the Bed; up he gets, Boots and all, not regarding the Holland-sheets; and falls to rolling the man's Belly with a Rolling-pin; the Patient's Fundament sounds an alarm, and certifies all the company that case was a coming."

Lactopeptine.—In the treatment of cholera infantum and other intestinal troubles so frequently met with among children and teething infants at this time of year, Lactopeptine will yield very satisfactory results; relief and recovery often follow rapidly after its use. We have no hesitation in recommending the preparation as one of great value.

Maltine in Phthisis. By Wm. Porter, A.M., M.D.—"After full trial of the different oils, and extracts of malt preparations, in both hospital and private practice, I find maltine most applicable to the greatest number of patients, and superior to any remedy of its class. Theoretically we would expect this preparation, which has become practically officinal, to be of great value in chronic conditions of waste and malnutrition, especially as exemplified in phthisis. Being rich in *diastase*, *albuminoids*, and *phosphates*, according to careful analysis, it aids in digesting farinacious food, while in itself it is a brain, nerve and muscle producer. In practice, this hypothesis is sustained. A female patient at St. Luke's Hospital, aged 35, with phthisis, signs of deposit in left upper lobe, losing flesh for six months, poor appetite and night sweats, began taking Maltine March 13th, 1880. She now weighs 121 lbs., eats well, no night sweats, and the evidence of local diseases are much less marked. Another case of phthisis: A gentleman from Alabama, with all the physical signs of phthisis, rapidly losing health and strength. His was the remarkable gain of 10 lbs., *from six weeks use of* Maltine. These instances are sufficient for illustration, and are *duplicated many times in the experience of physicians everywhere.*"—*Quarterly Epitome of Practical Medicine and Surgery.*

CANADA

MEDICAL & SURGICAL JOURNAL

SEPTEMBER, 1882.

Original Communications.

THE PRESIDENT'S ADDRESS, CANADA MEDICAL ASSOCIATION.

By GEO. E. FENWICK, M.D.

Gentlemen,—My first duty in addressing you is to return thanks to my professional brethren for the high honour conferred by them in electing me to fill this chair. When I consider the many able and gifted men amongst us, I feel that a far better selection might have been made. I can only bow in submission to your will, and at the same time assure you that I shall do my best to perform the duties imposed, trusting to the charitable judgment of all for any shortcomings on my part. I fully appreciate the high position I am called upon to fill. The Canada Medical Association is not confined to the members of our profession of any one Province of this vast Dominion ; our doors are open to all regularly qualified practitioners in good standing throughout the length and breadth of this Confederation. We are in fact an Association which represents the medical profession of the entire Dominion, hence it is no small honour to be nominated the presiding officer over a body of scientific gentlemen so constituted.

I do not propose on this occasion to discuss any subject of special professional interest, nor shall I inflict on you a lengthy address on the objects and aims of our Association, but shall, in a general way, touch on such topics as I feel it will be of advantage to dwell upon, if not to take some action upon with a view of

strengthening our hands and of giving greater importance to these gatherings. The benefit to us all of these meetings must be considerable. Men holding different opinions and of varying mental capacity meeting together and becoming familiar with each other's views and observations on various topics, must be of special benefit. It will awaken a spirit of emulation and a desire for a more careful record of facts, and I trust a willingness to give for publication in some of the medical periodicals of our country any new facts that may have been observed. But it is not alone new facts which are worthy of record ; careful reports of cases, medical or surgical, must be of use. They add to the store which may be already full almost to repletion, still though a repetition of an oft told tale, attention will be directed to the subject, and the writer will feel that by publishing his observations he is advancing the best interests of his profession. We are, each one of us, bound to impart our knowledge to our fellow practitioner if we believe that it will be of service in relieving human suffering. In this lies the great difference between the charlatan and the honest physician or surgeon.

We have, each one of us, received a sacred trust, which has to be distributed for the relief of suffering humanity. These meetings are of use in bringing together comparative strangers, in forming firm and lasting friendships, so that, as a band of brothers, we engage in work which may be of benefit to the entire human family. This may, at first sight, seem a startling thought, but of its truthfulness there can be no doubt when we consider the cosmopolitan nature of our calling. As physicians and surgeons we are in verity citizens of the world, owing allegiance solely to our Creator.

Nothing can tend more to the diffusion of knowledge than the coming together of men of cultured minds, for the purposes of discussion and consultation on subjects forming a part of those sciences to which they have devoted their lives.

The programme before us is various ; the subjects will have to be discussed in the order of our work, yet I may remark that a wider field will be indulged in when, outside these meetings, man

meets man in social converse, each one ready to impart, and each ready to receive, something that they did not know before, —some new idea—some new suggestion. Each one of us, I doubt not, has something to impart, or he may believe that he has. To do so in honest kindliness will materially add to the importance and success of these meetings, because any views brought forward will be the text on which an interesting and instructive debate will follow. It is to be desired that discussion should, as far as possible consistent with the time at our disposal, be fostered. We meet for that purpose; not so much to hear the dogmatic enunciations of adepts in our art, as to take cognizance of the views, expressions, observations and records of all who have anything to say. Seeing, then, that this is so, and I feel that it will give greater satisfaction to you all than otherwise, I shall advise that we meet in sections, which, according to the second division of our By-Laws, we are enabled to do. The clause reads as follows:

"The general meetings of the Association shall be restricted to the morning sessions. The afternoon sessions shall be devoted to the hearing of reports and papers and their consideration in the following sections—

1. Chemistry, Materia Medica, and Medical Jurisprudence.
2. Practical Medicine and Obstetrics.
3. Surgery, Anatomy, and Physiology.
4. State Medicine and Psychology.

The members of the Association assembled shall have power to to resolve themselves into sections and choose their officers."

By this method two or more sections can be carrying on the business of the Association at the same time, a larger amount of purely scientific work will be transacted, and each member will have an opportunity of hearing the opinions of his fellows and of expressing his own.

In all subjects for discussion we expect something new—something that has not altogether appeared to us as holding the same relationship, or of being of such importance as it is regarded to hold by the propounder of the question at issue; in all such debates we should be ready to receive truths, if they are truths,

and admit them if proven, for if dogmatic argument is persisted in, one object of this meeting will be frustrated. The mind, like the body, should be capable of adaptation or accommodation, yielding with pliancy to the varying conditions in which it may be placed.

We may believe that in scientific research, as under other conditions, wherever work has to be accomplished there will be found men with minds capable of undertaking it. Work undertaken and carried out by independent minds will in all likelihood vary in results. These, if persisted in, will lead to disagreement and discord. How necessary, then, for such assemblies as these, at which workers can compare notes and criticise one another's work with a view of arriving at something like consent and agreement of purpose.

The mission of this Canada Medical Association has not, so far, been developed. We are unable to point with satisfaction to what has been done in the past, but we must believe that our Society will in time be looked to for an expression of opinion bearing on public questions which appertain more especially to our profession. We may take cognizance of the influence for good in the councils of the nation which has attended the working of the British Medical Association—a society of medical practitioners embracing the three kingdoms of Great Britain and Ireland, and numbering some 10,000 members. Fifty years ago this Association was founded in the Board-room of the Worcester Infirmary. If we desire to emulate the usefulness of that society, much in the way of organization has yet to be done. It is acknowledged that the work of the British Medical Association, such of it at least as has to deal with public questions, is in a great measure transacted by the Branch Associations, of which there are many in England, Scotland and Ireland. I should gladly see a similar scheme introduced amongst us, for with Branch Associations holding meetings quarterly or oftener when necessary, the course of events bearing on matters of general interest, and which essentially belong to us as a profession, would be constantly under careful scrutiny, and many circumstances which are now passed over from being forgotten would be brought

to light and acted upon, with the full weight of the parent society, as being the expression of opinion of the profession of this Dominion. In England the Branch Associations are regarded as forming the strength of the Society, and the experience of our brethren on the other side of the Atlantic in this matter may well be taken advantage of by us in Canada.

The British Medical Association has but recently celebrated its jubilee, and we in Canada might be fast approaching the fiftieth year of our existence but for the unfortunate disagreement of those who had the matter in hand. It may not be known to all, and I place it on record because the sources of information are fast disappearing from amongst us. Nearly all the actors in that drama, which culminated in the city of Montreal on the 20th August, 1845, have passed to their rest. I must premise by stating that at that time in matters medical, the profession of this country was governed by an Act or Ordinance passed in the 28th year of the reign of His late Majesty King George III. This was felt to be a grievance, as the profession had slight recognition and no protection. In fact, we were without legislative recognition of any kind as affecting portions of the country which as individual towns or districts had no existence when the said Act or Ordinance became law. With a view of obtaining legislative powers and of advancing the general interests of the profession in united Canada, the various societies throughout Canada, at the suggestion of the Medico-Chirurgical Society of Montreal, appointed delegates, who met at Montreal on the 20th of August, 1845. For we find the following record on the minutes of that Society:

"At a meeting of the Medico-Chirurgical Society of Montreal, held on the 21st July, 1845, the following resolution was unanimously adopted: Moved by Dr. Badgley, seconded by Dr. Crawford, 'That delegates be now selected by the Medico-Chirurgical Society of Montreal to meet those to be named by the Quebec, Toronto and Niagara District Medical Societies, said meeting to be held in this city on the 20th August, 1845, to adopt measures for the foundation of a Provincial Medical Association, the formation of by-laws for its governance, and the

general purposes contemplated for advancing the interest of the profession in this Province.' "

Three gentlemen were sent from Toronto and Niagara District Medical Societies. Two, whose names do not appear, and who represented the Niagara District, arrived in Montreal on the 16th August, but left before the meeting on the 20th, and they concurred in the appointment of the late Dr. Hodder as sole representative for Western Canada, that gentleman, with his acknowledged pertinacity, remaining behind to watch the current of events.

At the meeting of the 20th, the following Societies were represented by delegates: five delegates from the city of Quebec, three from the District of Three Rivers and St. Francis, five representing the city of Montreal, and one representing the District of Toronto and Niagara.

The following proposal was moved by Dr. Badgley, seconded by Dr. Marsden:—"That an Association of the licensed practitioners of the United Province of Canada be now formed, with a view to excite and encourage a more extensive cultivation of all the departments of medical science, and thereby to elevate the character of the profession; to superintend, protect and maintain the rights and privileges of its members; and to induce among them cordial co-operation in what relates to their common calling, as well as friendship and good feeling in their private relations." It will be hardly believed that this motion was rejected by a deliberate vote, and it is greatly to be regretted that the rejection of this first proposition appears to have broken up the meeting, and the deliberations terminated.

In giving this historical sketch, I merely record a fact which is to be found elsewhere, that a desire existed at that early period in our history to establish an Association with like objects as our own, which was strangled wantonly in its very birth, and, strange to say, by the very men who had for months watched over its development with apparent solicitude. We must believe that, had it been otherwise, had the wise counsels of the minority prevailed on that occasion, and had the Association been consummated, very different would be the

position of our profession as to standing and usefulness at the present day. These observations are made with a view of goading us on in the course we are pursuing, and I trust that instead of relaxing our efforts, we will endeavour by all means at our disposal to strengthen, consolidate and unite, by which policy we can depend on increased usefulness and importance to the Canada Medical Association.

HEALTH STATISTICS.

It becomes my duty to bring under your notice the subject of Health Statistics, although I hope we shall receive an exhaustive report from the Chairman of the Committee appointed by this Association at our last meeting in Halifax. That committee was requested to continue communication with the Dominion Government with the view of securing important legislation in respect to sanitation and vital statistics.

It is reported of the late Lord Beaconsfield that when as Mr. Disraeli he addressed a public meeting at Manchester, he said: "I think that public attention should be concentrated on sanitary legislation. I cannot impress upon you too strongly my conviction of the importance of the legislature and society uniting together in favour of those important results. After all, the first consideration of a Minister should be the health of the people." In England the watchword of the Legislature for some years past has been "*Sanitas sanitatis, omnia sanitas.*" Thoughtful legislation bearing on the enforcement of sanitary regulations, each session forms a part of the business of the English House of Commons. But in England statistical inquiry has long been in existence, so that a sanitary topography of the country is available. It would almost appear that we in Canada do not really and truly appreciate the great and overwhelming importance of this subject. We hear the head of the British Government openly declaring with all the force and power of which he was capable, "that public attention should be concentrated on sanitary legislation." May we hope that similar words will be used by some leading member of the Executive at Ottawa? Nothing less than this should satisfy the Canadian people. It is a subject which affects our lives, our homes and little ones. Its

successful inauguration means progress and the enjoyment of all the blessings which are showered upon us, and its neglect will be attended by waste, in the death through preventable disease, of many whom we can ill afford to lose ; the lives of the people wasted, lost, neglected, exterminated by pestilence that we have the power to avert.

We are without any comphrehensive scheme for the collecting of sanitary statistics. It is a matter of great difficulty, although very desirable. We ought to be able to point out the localities of the occurrence of disease, endemic or epidemic. The Government at Ottawa is desirous of receiving suggestions, and to show its earnest appreciation of the necessity for some action in the matter, a sum of $10,000 is placed at the disposal of the Minister of Agriculture for the purpose of securing reliable returns and giving to the country a report thereon. At best the report, with such an extent of country and so small an amount to work with, will be limited in extent. My own impression is that the collecting of the returns can only be secured by municipal regulations.

Two separate and distinct kinds of work are involved in this labour. First. The collection of facts ; in this lies the chief difficulty. We cannot expect that voluntary reports will be forthcoming, and unless a general consent is obtained from medical practitioners throughout the country failure will follow, and the reports be utterly useless and unreliable. It has been proposed by one who has given this matter some thought, to appoint a certain number of enumerators, one, I believe, in each electoral division, who is to receive an insignificant stipend, for which he will be expected to give the reports of the extent and results of the practice of his *confrères* under their own signature ; said reports to be kept by the practitioners on schedules furnished by the Government. This scheme appears somewhat Utopian, and, I cannot but think, would fail.

The second point is, the arrangement of these facts, when gathered, into a condensed form for publication and use. This, of course, would be a matter for the Department to deal with, and I doubt not would be efficiently done. Any schedule that

is adopted should be easy of comprehension, simple in detail, so as to facilitate the work of enumeration.

It would be better for the present to limit the collection of statistics of disease to those cities and towns that have already some organization, as the existence of local Boards of Health or a Health Officer. We would thus obtain some trustworthy information. A commencement would be made, which would stimulate other localities to follow in the good work, and in time valuable and reliable reports would be obtained. To aim at too much, at the outset, will overtax our ability and may end in failure, or, what would be equally humiliating, inaccuracy.

I should furthermore suggest that a committee be named to confer on this important measure, and report to this meeting, so that, as an Association, we may be prepared to lay our views respectfully before the Government at Ottawa. The subject of public health was regarded to be of such importance by our American neighbours a few years ago, that at a meeting of their Medical Association, a resolution was passed, recommending the establishment of a National Sanitary Bureau at Washington. This was accomplished, and has been of great service, although the reports published in the "National Board of Health Bulletin" (an official periodical), have been questioned as to accuracy. Our neighbours are, however, working up the subject, and ultimately we may believe that the information which takes the form of a weekly report will be valuable and perfectly reliable for accuracy.

CHRONIC CEREBRAL ABSCESS, IDIOPATHIC (?)

By H. N. VINEBERG, M,D., Portage La Prairie, Man.

I was called on May 6th, in consultation, to see Mr. C. T., who, it was said, had been on a bad drunk a few days previous, from which he did not appear to recover. He had left his house on the evening of the 2nd of May, and was brought back by some one on the following evening in a state of intoxication, which seemed not to pass off, as he remained delirious and incoherent. The patient, a man of medium stature, intelligent appearance, and about 45 years of age, lay in bed in a state of

semi-stupor, from which, however, he could be easily roused. Now and then he would make a sensible reply to a question, but this would appear to be mere chance, for on immediately repeating the question the answer would be foolish and irrelevant. He talked almost incessantly during our visit. Some things which he said applied correctly to past events, but the greater part was "sheer nonsense." He misnamed several articles shown him—*e.g.*, a watch he called a "map," but when he was told what it was, he said, "Of course it's a watch." This, however, did not occur in every instance he was corrected. On being asked if he had any pain, he lifted his hand to the left side of his head. The pupils were equally contracted, and responded slowly to light. There was no paralysis of sensation or of motion. Pulse 52, regular and full; temperature 98°F. Tongue large, flabby, and heavily coated with a white fur. Bowels constipated. Urine scanty, high-coloured, but no albumen. Lungs, heart and liver apparently healthy.

Looking upon the case as other than that of chronic alcoholism, a careful investigation of the patient's antecedents was entered into, and the following facts elicited from his wife, a sensible and observant woman: He had always been addicted to liquor, but during the previous four years had drunk very hard. In May, 1881, he came to Manitoba, and since then had not imbibed so freely. She (his wife) and family followed him in November, and on their arrival she found him looking haggard and thin. On expressing the change she noticed, he told her he had been occasionally ill during the summer, and at one time had been a week in bed with what they call "Red River fever." Six days after their arrival he was laid up with some illness which kept him in bed for a fortnight and in the house for three weeks more. The first few days he had several chills, but these were arrested by the then medical attendant. He did not appear to have any fever, his appetite was fairly good, the bowels regular, but he seemed to have lost all energy and vigour, and was *melancholic* and *fretful*. She paid no attention to the latter, attributing them to his brooding over their reduced circumstances. About the middle of February, '82, while at Brandon, he was seized,

after an exposure to cold, with chills, fever, severe pain in the left ear and side of head. In four days the ear "burst" and there was a slight discharge of matter, with great relief to all his symptoms. A couple of days after this he was brought home, and his wife syringed the ear for four weeks, though there was very little or no discharge, scarcely enough to soil the wadding he wore in it. From that time he was deaf in the ear, and he *occasionally* complained of pain in the left side and front of his head. From the same period dated a *gradually increasing failure of memory*, with a change of disposition. He grew "peevish and irritable." On April 4th, was again laid up for a few days, was delirious, and complained a great deal of pain in the left side of the head. He recovered sufficiently to get about, but never did a day's work afterwards. So far as she knew, the only injury he had ever received was during a drunken brawl four years previous. Some person knocked him down and left the marks of the nails of his boot-heel over his left eyebrow. He was not rendered insensible by the blow, nor did any untoward symptoms follow. She thought that since then liquor had a more violent effect on him—"the effect of making him crazy." Family history good, and he had always been a strong, healthy person.

The case was now looked upon either as cerebral tumour or abscess, but the probabilities appeared to weigh in favour of the former; the absence of any fever militated against the latter as following the "ear affection."

May 7th.—Had a restless night. At the visit he spoke sensibly for a few minutes. He said he was not "crazy," that he knew everything that was going on around him, but that he could not find the right words to express himself. "The whole trouble," he said, "lies here," and he put his hand up to the left side of the front of his head. Pulse 48, volume good; temperature 98°F.

May 11th.—Has been growing violent for the past three days. It is with difficulty he is kept in bed. Pulse 52; temp. 98½°F.

May 12th.—Since yesterday's visit, has been sleeping the greater part of time. His breathing is heavy, and he sleeps

with his mouth open. Pupils equal, and rather small; pulse 52, small and weak; temperature 98°F.

May 14th.—No change; pulse 48 in sleep and 60 when roused.

May 20th.—During the past couple of days has been more awake, and occasionally gives a sensible reply. With the kind assistance of my friend Dr. Higginson, an examination of the eyes and ears was made. The left membrana tympani was found completely gone; right normal. No marked changes were observed in the papilla retinæ; the left was thought to be paler and its vessels more distinct than the right. An expert would probably have discovered some changes. The vision, however, had always been good, and when tested in his sane moments, appeared normal. Pulse 64, volume and power tolerably good; temperature 98°F. Has a troublesome, hacking cough, due to mucous accumulating at back of throat.

May 30th.—Has remained much the same until three days ago, since when he has been very noisy and violent. His wife says she noticed that he does not use his right extremities so much as his left. I cannot detect any difference in the power of the two sides. Pulse 76, soft and compressible; temp. 98°.

May 31st, 7 *p.m.*—A small swelling made its appearance this morning in front of the left tragus, which has been gradually extending. It is tense, globular, and extends downwards in the direction of the fibres of the masseter muscle. The skin covering it is red and hot, and the patient offers resistance when it is touched. Pulse 120, weak and compressible; temperature 102°. Poultices to be assiduously applied to swelling.

June 1st, 11 *a.m.*—Passed a restless night. Swelling increased in size, and gives the sense of deep fluctuation. As a *dernier ressort*, it was decided to make an incision into the swelling. Dr. De la Haye, the attending physician, cut down freely at the dependent part, in front of the lobe of the ear. A grooved director was then passed into the opening, and over this a pair of dressing forceps, and the deeper structures thus ruptured. Some dark blood oozed out, but no pus. The poultices were ordered to be continued. Pulse 126, weak, irregular and compressible; temperature 101°F. Left pupil

smaller than the right, and very sensitive to light, while the right responds, but very slowly. Died at midnight, apparently from exhaustion.

The treatment consisted of the administration of the bromide and iodide of potassium, blisters in front and behind the ear, and purgatives to keep the bowels soluble. The diet was bland and nourishing.

Autopsy, 16 hours after death.—*Brain*—Left hemisphere very much congested; vessels full of blood, but no effusion of lymph along this course. Occupying the left middle lobe is an abscess the size of a small hen's egg, possessing a very thick fibrous capsule. It lies loosely imbedded in the white matter (which, to the naked eye, appears normal), and small portion of the sac is visible at the outer and inferior part of the lobe near the fissure of Sylvius. The sac at this point presents a small valvular opening, scarcely large enough to admit the point of a surgical probe; the opening is filled with pus, which, on the slightest pressure of the sac, exudes freely. The pus is of a dark-greenish colour, and is quite colourless. No effusion in the ventricles; dura mater normal. No evidence of diseased bone anywhere. The cut through the skull anteriorly is high up, and the frontal bone on the left side at this point is much thicker than on the right, but the bone appears healthy, and the dura mater is normal at this part.

The other organs were not allowed to be examined.

It is through the kind permission of Dr. De la Haye, the medical attendant, that I am enabled to publish the case, which I think presents several points of interest.

1. The absence of any known cause. I think we may confidently exclude the ear trouble three months prior to death as the cause. There was no diseased bone, no inflammation of the membranes, the situation was unfavourable, and, what is most conclusive, the abscess must have been forming long before he had the ear affection. The thick, firm, fibrous capsule of itself indicates an older existence, and the clinical history, in my mind, points unequivocally to an earlier date. We can, I think, safely say that the illness accompanied by chills in the beginning of

November owed its origin to the brain lesion. This may even have been in existence prior to that date. His health had been poorly all summer, and for a week he had been in bed with what "they call the Red River fever," Again, the slight injury he had received four years previous, as related above, cannot reasonably be held in the relation of cause. In so far, then, as we know, it adds one to that unsatisfactory list of cases—the Idiopathic. 2. Its insidious course and the several periods of latency resembling, in these respects, tumour. 3. The absence of any paralysis, either of sensation or of motion. 4. The peculiar form of aphasia. In this connection it may be of interest to mention a point left out in the report. During the last three weeks of his life, when asked to show his tongue, he would open his mouth widely, and apparently make considerable effort to protrude the organ, but without any success. I have kept him for a minute or more at a time urging him on, but the tongue would refuse to leave its cavity. 5. The absence of any fever during the terminal stage until two days before death. The fever coincided and doubtless was caused by the sixth point of interest. 6. The appearance of the tense inflammatory swelling in front of the left ear 36 hours before the end. Is it not probable that this was produced by a couple of drops of pus from the overflowing capsule trickling through one of the foramina in the skull and finding its way into the cellular tissue in the vicinity of the masseter muscle, in which it excited inflammation? But why, it may be asked, did the pus not set up inflammation in the meninges? Let pathologists solve the problem.

CASES IN PRACTICE.

By JOSEPH WILLIAMS, M.D., Boston, Mass.

Case I.—*Infantile Convulsions with Aphasia.*

It is not common to find aphasia, associated with hemiplegia, occurring during infantile convulsions, and the following case may be interesting, as it illustrates complete and rapid recovery from these conditions:

D. V., æt. 2½ years; female; good physique; has enjoyed excellent health; was an intelligent and fluent talker for her

age. During a severe thunderstorm (July 19th), she was seized with a convulsion, from which she recovered after the use of a hot bath given by the parents. An hour later (4 P.M.) she was again seized, and remained unconscious until the following morning. After she had been in an unconscious state nearly two hours I was called. At this time there was no paralysis to be detected in the limbs, but the eyes were strongly rotated to the *left*. The spasms were nearly continuous, and affected all the limbs equally. Used hot mustard bath and enemata of Potass. Bromid. with Mist. Assafœtidæ, but without success. Head now rotated strongly to the *left; right* arm and leg lie passive, except there is slight twitching and trembling, which persists in the intervals between the convulsions. The paroxysms continuing to be severe, I began the use of ether, and kept the child more or less completely under its influence for nine hours. During that time the convulsions reappeared if the ether was removed for five or ten minutes. Altogether I used slightly over one pound of Squibb's ether. The temperature during the night ranged from 103° to 104°; pulse, 150 to 165. Shortly after beginning the use of the ether I leeched the left temple and kept up bleeding by warm fomentations.

As the effect of the anæsthetic passed off it was seen that there was *right*-sided hemiplegia; slight, almost continuous tremors of paralyzed limbs and mouth; nystagmus, horizontal; rotation of eyes and head strongly to the *left;* ptosis on *left* side; partial paralysis of sensation of affected limbs; drawing down of *left* angle of mouth; inability to protrude tongue; strong visible pulsations over precordial and carotid regions; and complete loss of speech.

Second day.—Intelligence improved; no power over paralyzed limbs, but less tremor and more sensibility; eyes well under control; head not rotated to left; the tongue cannot be protruded, although the child attempts to do so. The aphasia is evident; when spoken to the child appears to understand, and attempts to answer, but only succeeds in making an inarticulate sound; said "no" once, but not distinctly. Temperature, 103°; pulse, 144; respiration, 42, at 7 P.M. Treatment—Quiet and

rest, cold to head, and internally Potass. Iodid. gr. iv, with Syr. Ferri Iodid. ♏v t.i.d.

Third day.—Slight voluntary movements of affected limbs; very little distortion of mouth in swallowing; cannot protrude tongue; makes only inarticulate sounds. Temperature, 101°; pulse, 125.

Fourth day.—Power over limbs markedly increased, and tremor has ceased; made use of the words "milk" and "chair." Temperature, 99°; pulse, 125.

Improvement continued steadily; child walked with some awkwardness on eighth day; perfectly on the ninth; has not spoken a word since last note; protrudes tongue readily without deviation.

I did not see the child again until the twentieth day, when I found she had regained the use of many words, but did not speak as freely as before illness; could not be induced to repeat words after her friends. It is worthy of note that she appears to remember perfectly incidents that had occurred before her illness.

CASE II.—*Spasm of the Glottis treated by Nitrite of Amyl.*

In this case I had been treating the child, aged nine months, for simple diarrhœa of two days' duration. This was readily controlled, but on the morning of the third day I was sent for in haste, as the child was thought to be suffocating. I found the child had slept naturally, but about 6.30 A.M. had a very slight spasm of the arms and legs, and at once began to breathe heavily, and became unconscious in about ten minutes; there was no cough at any time. At 7 A.M. the hands and wrists, feet and ankles, were cold and purplish; lips livid; breathing very labored, 16 per minute; expiration much prolonged; sinking of whole chest wall at each inspiration; pulse thready, and child quite unconscious. The use of cold having no effect in reviving the child, I sent one messenger for Nitrite of Amyl and another for assistance, with a view to possible tracheotomy. I caused the child to inhale the contents of two 5-minim. pearls of the nitrite so gradually as to cause only slight flushing of face; almost immediately the stridor ceased, the breathing improved, the surface became warmer, pulse more distinct, and in perhaps

two minutes the child was in a deep sleep, which lasted about twenty minutes. A hot bath, linseed poultice to abdomen, and internally Potass. Bromid. 2½ grs. every two hours completed the treatment. Child was as well as usual next day.

I report this case simply to bear testimony to the value of Nitrite of Amyl in an urgent case, and also because I am not aware of its having been used in this affection.

QUARTERLY RETROSPECT OF SURGERY.

Prepared by FRANCIS J. SHEPHERD, M.D., C.M., M.R.C.S., Eng.

Demonstrator of Anatomy and Lecturer on Operative and Minor Surgery McGill University; Surgeon to the Out-Door Department of the Montreal General Hospital; Consulting Surgeon to the Montreal Dispensary.

Excision of the Tongue.—Mr. Walter Whitehead, F.R.C.S., F.R.S.E., &c., in a paper in the London *Lancet* of Oct. 22, 1881, reports 28 cases of excision of the tongue through the mouth, with only one death from the operation, that of an old man aged 69. He first performed his operation of removal of the whole tongue through the mouth, with scissors, in November, 1877. The operation is conducted as follows:—

1. The mouth is opened to the full extent with a gag. This duty is entrusted to an assistant.

2. The tongue is drawn out of the mouth by a double ligature passed through its substance an inch from the tip. This ligature is given in charge of another assistant, who maintains throughout the operation a steady traction outwards and upwards.

3. The operator commences by dividing all the attachments of the tongue to the jaw and to the pillars of the fauces, after the manner suggested by Sir James Paget, with an ordinary pair of straight scissors.

4. The muscles attached to the base of the tongue are then cut across by a series of successive short snips of the scissors until the entire organ is separated on the plane of the inferior border of the lower jaw, and as far back as the safety of the epiglottis will permit.

5. The lingual or any other arteries requiring torsion are twisted as divided. It is generally found that a moment's pres-

sure with a small piece of sponge held in a sponge forceps suffices temporarily, if not permanently, to arrest any bleeding; it is, however, regarded as desirable to twist immediately, or after the tongue is removed, every bleeding vessel.

6. A single loop of silk is passed by a long needle through the remains of the glosso-epiglottidean folds of mucous membrane, as a means of drawing forwards the floor of the mouth should secondary hemorrhage occur. This ligature may safely be removed the day after the operation.

Mr. Whitehead recommends that the after treatment should consist in feeding the patient for the first three days absolutely and solely by nutritive enemata, satisfying thirst by occasionally washing out the mouth with a weak iced solution of permanganate of potash. Speaking should be forbidden.

This operation of Mr. Whitehead's is now quite an established one in surgery, and, for the removal of the *whole* tongue, is preferable to any other. It is easily performed, requires few instruments, and more certainly removes the whole tongue than where the écraseur is employed.

Mr. Henry Norris, F.R.C.S. (*Lancet*, May 30, 1882), in a paper on *Epithelioma and Ichthyosis of the Tongue based on the records of seventy-five cases*, gives some observations on the relative value of different methods of excising the tongue. These observations are confined to cases, twenty in number, operated on by himself. *Six* operations were done with the galvano-cautery écraseur, and in one of these the cheek was divided obliquely downwards from the angle of the mouth, after Gant's method. *Seven* were done with the twisted wire écraseur, and in one of these also the cheek was divided; in two, the twisted wire rope was passed into the mouth through a supra-hyoid incision, and in two the wire was looped round the tongue without any preliminary incision; in the remaining two cases of this series only the anterior portion of the tongue was removed. *Three* cases were operated on by the twisted wire écraseur after median division of the tongue. In *four* cases the knife or scissors were used to remove the organ.

The average period of convalescence in five of the galvano-

cautery cases was 32.4 days. The shortest, 26 days; the longest, 50 days. The sixth case died. The average period of convalescence after median division (three cases) with the twisted wire écraseur was 21 days; shortest, 16 days; longest 27 days. The average period of convalescence of five cases operated on with the twisted wire écraseur was 19.2 days. Two patients were well in 12 days; the longest 27 days. In the sixth case where the suprahyoid incision was used, a fistula remained for a year; and in the seventh case, recurrence took place before the wound was healed. In three cases where the cutting operation was performed, the average period of convalescence was 16⅓ days. In the fourth case, where the symphysis was divided, the bone did not unite for five months.

Mr. Morris remarks that the amount of tongue removed does not affect the length of the period of convalescence. He does not recommend the supra-hyoid incision; he says it is not necessary for drainage, and that a fistulous opening is liable to remain. When more room is wanted to get at the base of the tongue, Mr. Morris prefers the division of the cheek from the angle of the mouth; the wound heals readily, leaves but a slight scar, and adds nothing to the risk of the operation. He considers that division of the symphysis is the most formidable and least favourable method of operating, and is only necessary when the mucous membrane on the inner surface of the jaw is affected and cannot be otherwise removed. In his earlier operations, Mr. Morris employed the galvano-cautery écraseur; this he has now discarded; the slough which follows is most offensive, and the period of convalescence prolonged. He now prefers the twisted wire écraseur, but cannot recommend any one method of operating, as the operation must be planned to suit each individual case. His recoveries after the use of the twisted wire have been more rapid, and hemorrhage is seldom or never troublesome. He considers the most important safeguard of the operation to be the passing of a stout ligature through the root of the tongue, behind the line of operation. By traction upon it, this ligature not only assists in counteracting the tendency of the écraseur to drag the cheek needles forward, but prevents the stump from

falling back over the top of the larynx. Mr. Morris says that the mortality after operations on the tongue does not amount to three per cent.

With regard to the after treatment, two points are dwelt upon: (1) feeding by the rectum at intervals of not more than four hours from the day of operation till plenty of nourishment can be swallowed; and (2) frequent and thorough irrigation, especially just before and after taking food through the mouth. Irrigation should be continued until the wound is healed. In cases in which secondary hemorrhage has occurred, half drachm doses of liquid extract of ergot and the local application of styptic colloid have been found most effective.

In the August number of this *Journal* a case is recorded where the tongue was removed for cancer by Dr. Roddick by means of the chain écraseur, combined with the cutting operation with scissors. The scissors were used to separate the tongue from the floor of the mouth, and the écraseur was then introduced through a suprahyoid incision. Convalescence took place on the 27th day. A tube was placed in the suprahyoid incision for drainage; after removal of the tube, the suprahyoid opening soon completely healed.

Mr. Henry Gray Croly, F.R.C.S., records two cases (*Dublin Journal Med. Science*, July, 1882,) of removal of the tongue, in which, before removal, he ligatured the lingual arteries by an incision extending from the symphysis to the hyoid and back to the angle of the lower jaw. The tongue was then drawn out through the incision below the jaw, as in Regnoli's operation, and removed without hemorrhage by means of a benzoline cautery. The period of convalescence is not given, but the patients recovered. I forgot to mention that the gustatory nerves were also divided for the purpose of relieving the ptyalism.

Mr. Bennett May, B.S., F.R.C.S., in a paper on *Excision of the Tongue, &c.*, (*Lancet*, June 10th, 1882), believes that, notwithstanding Mr. Jonathan Hutchinson's impressive appeal for early operation in cancer of the tongue, surgeons will not generally urge, nor will patients accept, any operation for the removal of a considerable portion of the tongue, until the other-

wise hopeless, and necessarily fatal character of the disease, is, to their minds, clearly established. In the case reported the cancerous disease was of rapid growth, and involved the floor of the mouth and lower jaw as well as the tongue. The tongue being secured by a ligature through its tip and the requisite teeth being extracted, Mr. May carried an incision through the median line of the lower lip, under the jaw, to terminate at the hyoid bone. The tissues, including the gum and periosteum on either side, were then dissected back nearly as far as the angle of the lower jaw on the left side. Holes were then drilled in the jaw outside the line of the intended section, the bone cut away with a straight saw, and the soft parts at the floor of the mouth divided with scissors. The tongue was then removed with a chain écraseur. Patient was fed by the rectum for six days; period of convalescence 28 days.

Dr. Fenwick, at the Montreal General Hospital, performed a very similar operation to this in a very similar case some six months ago. The patient recovered completely, and has since had no return of the disease.

In the *Annals of Anatomy and Surgery*, Dec., 1881, Dr. Joseph Howe records two cases of entire removal of the tongue, and describes a "safety-pin tourniquet," whose use, he thinks, will render the extirpation of the tongue an exceedingly safe and simple operation.—(*American Jour. of Medical Science*, April, 1882.)

Treatment of Acne Rosacea.—At the meeting of the Harveian Society, held April 27th, 1882, Mr. Malcolm Morris gave a short account of the treatment of severe cases of *acne rosacea* by scarification. He pointed out that there were two classes of cases: the one consisted of acne spots, surrounded by red patches, the nose being considerably enlarged from hypertrophy of the tissues; in the other there was flushing of the nose, erythema, a varicose condition of the veins, and hypertrophy without acne. It was in the latter class of cases that Mr. Morris advocated scarification. This condition of the nose occurred in people of feeble circulation, whose hands were generally cold, and who were easily affected by changes of temperature; in a

hot room the nose itched, and caused great discomfort; when exposed to cold there was great pain. The operation of scarification Mr. Morris performs as follows: First of all, the nostrils are filled with cotton wool to make the skin tense; next all the blood-vessels are slit up throughout their length by a knife double edged at the point, then with an instrument having a number of fine blades close together, the vessels are thoroughly divided transversely; free hemorrhage follows, which must be encouraged, and is beneficial. The clots and serum are absorbed by blotting paper, and the patient is enjoined not to touch the nose for several days. The scarifications heal in a few days, and leave no scars. This operation is to be repeated a number of times until the nose is reduced to normal. Mr. Morris had scarified 28 cases successfully; one which was done in 1879 has remained well ever since.—(*Brit. Med. Jour.*, May, 1882.)

The above mode of treatment is a modification of that employed by Hebra and Volkmann. Hebra employed a double-edged lancet-shaped needle, with a shoulder 2mm. from the point, to prevent it going too far into the skin. With this instrument the vessels were punctured deeply and rapidly. The punctures were made in horizontal rows. In mild cases the repetition of the punctures usually was not necessary. In the severer forms Hebra employed Volkmann's method, viz., shaving or scraping off the inflammatory products and hypertrophied masses with a Volkmann's spoon. The operation is not a painful one. He employed this method also to remove nævi, port wine stains and superficial taleangiectasis. The epidermis only should be removed. In the mild cases without hypertrophy, and with the formation of pustules, I have found that the evacuation of the pustules as soon as formed and the nightly application of sulphur ointment prove very beneficial. The ointment should be washed off in the morning, and the nose rubbed with a soft flannel, covered with the lather of Pear's transparent soap before being reapplied in the evening. I have also occasionally seen benefit derived from the application of chrysophanic ointment, 20 grs. to the ounce.

Dr. J. H. Staines, in a paper read before the Cambridge

Medical Society, on the *Nature and Treatment of Acne* (*Brit. Med. Jour.*, June 24th, 1882), referring to *Acne Rosacea*, dwelt on the necessity of simple diet, the avoidance of alcoholic stimulants, and the use of soap and water locally. He also recommended the application as many as 12 or 15 times daily of a lotion containing precipitated sulphur, camphor, glycerine and lime water. He spoke of the advantages of local depletion, and described an instrument devised by Volkmann for producing multiple punctures. In ordinary acne he advocated the use of precipitated sulphur, in the proportion of 4 drachms to 6 ounces of lime water, with 3 drachms glycerine and a little spirits of camphor.

New Antiseptics—Boro-Glyceride.—This was lately introduced by Professor Barff for the purpose of preserving meat during long voyages, and is a compound of boracic acid with glycerine. Mr. Barwell first introduced it into surgery, and has used it most successfully in place of carbolic acid. He holds that it is less irritating (*Lancet*, May 13, 1882) locally, and free from the danger of constitutionally poisoning. Mr. Barwell used it of the strength of 1-20. For the last six weeks I have used it at the General Hospital as a substitute for carbolic acid in moist dressings, and have been favourably impressed with it. Wounds seem apparently to heal with glyceride more rapidly than with carbolic acid. I use it of the strength of 1-30 or 40. In several cases of severe crushing injuries of the hand where it was used, healing took place very rapidly. It is rather insoluble in water, and I am now about to use a solution of it in glycerine, diluted with water.

Glycero-borate of Calcium and Glycero-borate of Sodium.—M. G. Le Bon has just presented to the Academy of Sciences the above new and very effective antiseptics (*Lancet*, Aug. 5th, 1882.) Both have the advantage of being very soluble, destitute of odour, and free from all toxic action. When exposed to the air they both deliquesce rapidly, absorbing from the air an equivalent weight of moisture. Both alcohol and water dissolve twice their own weight of these salts. They are powerful antiseptic agents, even in dilute solutions; the most effective thera-

peutically appears to be the glycero-borate of calcium. It is absolutely innocuous, and can be applied in strong solution to so delicate an organ as the eye without bad result. They are both good disinfectants and preservers of meat. M. Le Bon has transmitted meat simply coated with a varnish of the glycero-borate to La Plata, and it has arrived in a perfectly fresh condition. He thinks both salts will prove very useful as antiseptics in Lister's mode of dressing wounds.

These salts, from their solubility, will no doubt be an improvement on the boro-glyceride of Prof. Barff.

Dr. Geo. Thin (*Lancet*, May, 1882,) reports several cases of chancre treated by a solution of glycerum boracis, in which the sores healed with marvellous rapidity. The theory, says Dr. Thin, on which the method was conceived was that of keeping the surface of the sore saturated with a solution that would effectually prevent the development of organisms. He thinks this would prove a very suitable application for phagedæna and hospital gangrene.

Treatment of Carbuncle by Injection of Carbolic Acid.—Dr. Lopez Rubio records (*El Siglio Medico*, 1882,) a case of anthrax, in which treatment by subcutaneous injection of carbolic acid—a plan first suggested by Dr. Olavide—gave very remarkable results. The anthrax occurred in a man aged 30 years, and was situated in the interscapular region. It measured, when first seen, approximately, 7 inches vertically by 5 horizontally, the centre being occupied by a cone of dark-coloured sloughing skin. The constitutional disturbance was considerable, the pulse being 110, accompanied by pyrexia and severe headache. A five per cent solution of carbolic acid in water and alcohol was injected, with a Pravaz's syringe, into each of the four quadrants of the tumour. Next day the anthrax had decreased about one-half in its superficial dimensions, its angry complexion had departed, while nearly all constitutional disturbance had ceased. The same treatment was continued for two days longer, when the patient had so far improved as to be able to return to his work.—(*London Medical Record*, June, 1882.)

Dr. Chas. Taylor (*Australian Med. Gazette*, Dec., 1881,)

strongly recommends the injection of carbolic acid in the treatment of carbuncle. He has treated six typical cases, all seated about the nape of the neck, and occurring in men of good bodily health and condition. Five were treated, within the first three days of their existence, by injecting pure carbolic acid into them; the sixth had been submitted to free incision before any acid was used. The five cases treated without incision recovered rapidly; the sixth lingered on through two or three weeks of extensive sloughing and profuse suppuration. Dr. Taylor injects with a hypodermic syringe five or six drops of pure carbolic acid; the skin around should be smeared with oil to protect it from any acid that may escape. Little or no pain is felt when the acid enters the tumour; the patient at once becomes comfortable, and experiences a glow of pleasing heat passing throughout it. The carbuncle rapidly aborts, discharges a small quantity of pus, and ceases to trouble or runs through a few days of active suppuration, speedily terminating. One application of the acid is sufficient, aided by the usual linseed-meal poultices, fomentations, &c.—(*Edin. Med. Jour.*, Aug. 1882.)

Dr. Peter Eade (*Lancet*, July 22nd, 1882,) treats formed boils by the introduction of carbolic acid through their openings; he considers that boils are local, parasitic and contagious, and carbolic acid destroys the parasite. He also advises that boils should, in their early stages, be destroyed by a good caustic, as nitrate of mercury, nitric acid, strong carbolic acid, or nitrate of silver.

New means of Diagnosing Unilateral Renal Disease.—Th. Gluck, in the *Centralb. f. Chirurgie*, says: I need only mention in passing, as being generally well known, the method of Tuckmann, Simon's catheterization of the ureters and Hegar's ligature of the ureter from the vagina. By none of these are we guarded against unpleasant surprises during the course of the operation, or rather during the autopsy which soon follows it. A method in cases where nephrotomy is thought necessary, by which the presence of active renal parenchyma on the presumedly normal side might be determined with ease and celerity, would certainly tend to favour the general extension of this salutary operation.

I would suggest the following mode of procedure: The morbid kidney is exposed by means of a small incision made in the usual position at the edge of the sacro-lumbalis muscle. The ureter is then isolated and its lumen temporarily obliterated either with a ligature or a small clamp. A solution of some salt, which is rapidly excreted by the kidneys (potassium iodide), is then injected subcutaneously, and its presence in the urine is, after a short time, ascertained by the ordinary tests. If the result of the chemical examination be negative, the temporary ligature is removed from the ureter and the wound closed as after an ordinary exploratory incision. But should traces of the salt be found in the urine, we are assured that, functionally, active renal substance must still exist in the supposed normal kidney, and extirpation of the organ affected may be proceeded with. Two conditions may diminish the value of this test. (1) For reasons easy to understand, a lecotropal kidney would not be diagnosed with certainty; and (2) under peculiarly complicated anatomical conditions, the isolation of the ureter might be attended with great difficulties. I believe, however, that the ureter will in general be easily secured, so that the method is worthy of trial in the class of cases referred to.—(*Edin. Med. Jour.*, Aug. '82.)

The Coat Sleeve Method of Performing the Circular Amputation.—Mr. Richard Davy, of Westminster Hospital, describes the above novel operation in a clinical lecture (*Brit. Med. Jour.*, June 17th, 1882), and gives three cases to illustrate its advantages. He dissects back, as in the circular amputation, a sleeve of integument 3 to 6 inches in length. Then the soft parts are divided to the bone, and the periosteum carefully peeled off up to the point the bone is to be divided. After trimming off any projecting tendon or nerve from the stump, and tying the vessels, the skin sleeve is tied up with a piece of tape (very much like a bag of flour is closed up), the tape is passed through a cylinder, and the ligatures are allowed to hang through the crucial slit on the face of the stump. The wound may be treated with or without dressings. Mr. Davy prefers none. The surgeon must carefully watch that the tape does not strangulate the skin sleeve. Should the stump become œdematous or any necessity

for drainage arise, then a drainage tube may be inserted into the face of the stump. According to Mr. Davy, the advantages are: (1) The conservation of an abundance of skin, subcutaneous fat and areolor tissue, which, by mechanical arrangements, are utilized so that the scar is reduced to a minimum, and the cushions to a maximum. (2) The total abolition of sutures, which, however necessary, are invariably painful in removal; and the sutures, as previously employed, necessitated a linear cicatrix on the face of the stump. (3) The facility granted to the house surgeon for restraining, and to the patient for escaping, secondary hemorrhage. (4) Freedom from pain, exclusion of air, and adaptability for perfect drainage. (5) The symmetrical appearance and utility of the stump.

I should fancy that one great disadvantage of this operation, notwithstanding all said in its favour by Mr. Davy, would be the amputating of the limb higher up than was necessary to procure a sufficient amount of skin to make the "coat sleeve." Mr. Richard Davy is well known through his practical and racy "Surgical Lectures." His ingenuity is manifested by his operations for club-foot, his hammock suspension, and above all his lever for controlling hemorrhage in hip joint amputations. In this connection I may remark that during July last three cases of amputation of the right hip joint were performed successfully in England with the aid of Mr. Davy's lever. A case where Mr. McLaren, of Carlisle, operated, lost two ounces of blood; a second, under Mr. Cowell's care, at the Westminster Hospital, lost three ounces; and a third case, where Mr. Paul Swain, of Plymouth, performed amputation, lost but one ounce and a half.—(*Brit. Med. Jour.*, Aug. 12th, 1882.)

Strange Urinary Calculi.—Dr. Bennett, at a recent meeting of the Dublin Pathological Society (*Dublin Medical Journal*, 1882), showed some specimens of calculi presented to the Museum of the School of Physic by Surgeon-Major T. Robinson, of the Bengal army. The first example was a primary calculus of remarkable shape, not unlike a mushroom. It consisted of oxalate of lime, mixed with crystalline phosphate. The nucleus consisted of a bullet of moderate size, altered from its original

shape; the whole calculus weighed nearly an ounce. The bullet had entered through the right gluteal region and ilium to the bladder two years before removal.

Dr. Bennett remarked that several similar examples of rare interest are in the Museum of the College of Surgeons, Dublin, and were presented by Mr. Colles and Mr. Cusack. In Mr. Cusack's case the bullet has very little stone about it, and was removed two years after the receipt of the injury.

In the session of 1878-9 a subject was dissected in the anatomical rooms of McGill University,* in whose bladder was found an ounce bullet. It was partially encysted, and in parts coated with a thin covering of phosphates. Unfortunately, the track of the bullet could not be made out, as the dissection had gone too far before its discovery. The bullet was not at all altered in shape, and was one of the old "Brown Bess" variety, 16 to the pound. As the man had died in hospital of some lung affection, I was able to find out that he had been a soldier, and went all through the Crimean war, so that probably the bullet had remained in his bladder for 22 or 23 years.

It is a remarkable fact that bullet wounds of the bladder are much less dangerous than bayonet or knife stabs, or injury from fracture of the pelvis.

A New Method of Detecting Stone in the Bladder.—Mr. J. McK. Davidson (*Lancet*, July 1st, 1882), has devised an instrument for detecting stone in the bladder, which he terms a lithophone. An ordinary sound and about two feet of Indiarubber tubing is all that is required. One end of the tubing is slipped over the sound after it has been introduced into the bladder, and the other end held closely to the ear, and the bladder explored. Mr. Davidson says that the advantages are as follows:—(1) A small calculus can be detected, which would otherwise be overlooked. (2) Practice will enable the operator to distinguish the size and character of the calculus readily. (3) It is probable that a somewhat similar ear connection with a lithotrite will enable the operator to find and secure small fragments more readily and so crush them. I should suggest that instead of

*This specimen is now in the Medical Museum of the University.

holding the tubing to the ear an ear piece be fitted to it, and that it be used as in Politzer's method of inflating.

Dr. Geo. C. Duncan, formerly of Canada, some years ago published in the *Edin. Med. Jour.* a method of detecting small fragments of stone in the bladder. He coats a sound with a preparation of lamp black, and when it comes in contact with a fragment a scratch is made on the blackened end of the sound. I had the pleasure of seeing some experiments made of this method on the cadaver in the dissecting room of McGill University, and certainly was very favourably impressed with what it could accomplish in detecting very small fragments of stone.

Radical Cure of Varicocele.—Dr. Angelo Negretto records (*Gaz. Med. Ital. Prov. Venete*) two cases of varicocle, in which he succeeded in obtaining a speedy and permanent cure by intravenous injections of chloral hydrate. In the first case the patient was aged 28 ; the variocele was situated in the left side, turgid and painful. Dr. Negretto injected with a Pravaz's syringe, in four different places, a solution of chloral-hydrate, of seven grains to the ounce. At once a small hard knot could be felt in the lumen of the vein. Within a few hours a mild attack of orchitis supervened, which yielded readily to ordinary remedies. The injection was repeated in one or two other spots, with the same result of again inducing orchitis, which, however, was of the mildest possible type. Six days later all visible traces, both of the operation and the variocele, had disappeared. Along the course of the spermatic vein a few hard, small, and indolent nuclei could be felt, which corresponded to the seat of the punctures. The author remarks that in this case the obliteration of a few branches of the spermatic vein had evidently been sufficient to effect a cure. The second case occurred in an individual aged 23, in whom variocele had existed six years. Five injections were used, with the result of producing a clot in the vein, followed by slight orchitis, with severe pains radiating from the spermatic cord over the pelvis generally. A week after the last operation the cure was complete ; and as the patient never returned, the author believes it was permanent.—(*London Med.*

Record, May, 1882.) This method needs to be tested and tried in a greater number of cases before any deductions can be drawn as to its usefulness. In every case the orchitis produced may not be so mild as in the two reported, and the inflammatory affection of the veins injected with chloral hydrate may not always be so harmless.

Mr. Reginald Harrison (*Lancet*, March, 1882) describes a method of operating for the radical cure of variocele, which has given him the best results. He exposes the cord by a vertical incision about an inch in length, and separates the most prominent varicose veins. These are each tied in two places with a catgut ligature. Three or four of the larger veins are so treated; the smaller ones are destroyed by a few light touches of the thermo-cautery. The operation is conducted antiseptically, no sutures are introduced, and the wound is left to heal by granulation. He has been performing this operation for some years, and is not aware of an instance in which there has been a return of the varicose condition of the veins.

Excision of the Pylorus.—The *Wiener Medizin. Blätter* of May 18th, 1882, contains an account of a discussion, at a recent meeting of the Congress für Innere Medizin, on the Diagnosis of Carcinoma of the Stomach and on the operation of resection for that disease. Dr. Henck of Heidelberg read the case of excision of the pylorus for carcinoma performed ten months ago by Prof. Czerny, which was briefly described by the latter surgeon at the International Medical Congress, and is recorded in its transactions. It is satisfactory to learn that the patient, who gained eleven pounds weight at the end of the sixth week of the operation, was, at the beginning of last month, ten months after the operation, quite well, with no symptoms of recurrence of the disease. Dr. Henck tabulated the clinical history of twelve resections of the stomach. One, which recovered, was performed in a case of stricture of the pylorus, following perforating ulcer. The remaining eleven were for the removal of cancerous growths; *four* of these recovered from the operation; out of the recoveries three patients are still alive and free from any recurrence; the fourth is known to have died four months after the excision, from

a return of the disease. In the discussion which followed the reading of Dr. Henck's paper, Prof. Lichtheim observed that mobility of an abdominal growth detected by palpation in the region of the pylorus was no proof that, if the growth were pyloric, there were no adhesions. In a case under his care, the swelling could be freely moved about under the abdominal walls when the patient was narcotized; yet, on opening the abdominal cavity, the pylorus was so strongly adherent to neighbouring parts that its removal was impracticable. Prof. Kühle stated that the rapid implication of the chain of lymphatic glands in front of the bodies of the vertebrae behind the stomach, in cancer of that organ, renders many cases unsuitable for surgical treatment. Dr. Henck remarked that the same objection stands in the way of operation in cancer of any other organ. As early diagnosis is so important, Dr. Ewald asked if the members of the Congress could confirm the theory of Van der Velden that free hydrochloric acid was absent in the gastric juice in cancer of the stomach. No researches had been made, however, by those present who had some experience for the radical cure of malignant gastric disease.—(*Brit. Med. Jour.*, June 5th, 1882)

Dr. Richter of San Francisco, in the *Western Lancet* of July, describes a case of carcinoma of the stomach, in which he performed resection. The patient died three hours after the operation, but the operator attributed this in some measure to the anæsthetic.

Lawn Tennis Arm and Rider's Sprain.—Mr. Henry Morris (*Lancet*, July 29th, 1882,) describes a sprain of the pronator radii teres muscle due to playing lawn tennis. This sprain, Mr. Morris believes, is the result of the frequent back stroke whereby the forearm is brought into rapid and forcible pronation. The condition is slight swelling, with tenderness on firm pressure along the course of the pronator and pain in bringing the muscle into action, but, as a rule, not otherwise. If the forearm is enveloped in an elastic bandage or firm elastic webbing, and kept at rest, the symptoms soon disappear. In the same article he also describes the "Rider's Sprain," a sprain of the adductor longus. It occurs very frequently, and the surgical instrument

maker is often applied to for some remedial support. It is caused by the horseman suddenly making a strong grip owing to his horse rearing, shying, slipping, or unexpectedly taking a jump. According to Mr. Morris, the pain at the time is often very trivial, but subsequently more pain is felt on walking. Pain is confined to inner and upper part of thigh. In mild cases a long web or leather strap, 2 to 3 inches broad, and padded, is applied. This strap is passed round the thigh and pelvis like a spica bandage, outside the breeches, and firmly fastened in front. In In severer cases, where blood is effused, the surgeon is generally consulted. This, by the application of bandages and absorbents, generally disappears after a time.

Dr. Edward Henderson (*Lancet*, July 29th, 1882,) gives an account of an accident which happened to himself when taking a small water-jump in the neighbourhood of Shanghai. The muscle on the inner side of his thigh seemed suddenly to give way, and this sensation was attended with such acute pain that for some moments he had difficulty in retaining his seat in the saddle. On dismounting he was comparatively comfortable, and acute pain was felt only on movements of adduction. When he wrote, a week after, he was still unable to ride. He says the accident is of common occurrence and well known to horsemen. When a man has once sustained this injury, he is liable to a recurrence, and sometimes permanent weakness is left behind. He thinks the accident is quite common at Shanghai, owing to the riding of China ponies being very common. These being of small size, a stronger grip is necessary to retain one's seat.

Use of Salicylic Silk as a Dressing for Wounds.—Dr. J. L. Gibson, Mr. Chiene's House Surgeon in the Edinburgh Infirmary, gives (*Lancet*, July, 1882,) a table of a number of cases treated by salicylic silk in the antiseptic dressing. This method is an approach to dry dressing, which "Mr. Chiene has long been aiming at." Next the wound is placed a piece of protective of as small a size as possible, merely to prevent the dressing sticking to the wound, then two or three layers of carbolic gauze wrung out of 1-40 carbolic lotion, above that a variable quantity of salicylic silk, and over all 8-plies of carbolic gauze. By thus

getting rid of the Macintosh, its poulticing action is done away with.

Diagnosis of Hip Disease by Rectal Examination.—Dr. H. Cazin (*Rev. de Chir.*, March, 1882,) refers to the difficulty of diagnosing the exact seat of the disease, especially in regard to the acetabulum. Abdominal palpation enables us to detect enlarged iliac glands or pelvic abscesses; but if we also examine the patient through the rectum, the diagnosis will be more sure. The hip joint, from its deep position in the tissues, is not very accessible to ordinary methods of examination, but the finger can approach it most easily through the rectum. In the cavity of the pelvis, immediately above and a little behind the obturator foramen, is a quadrilateral surface of bone, corresponding with the bottom of the acetabulum. In a child under 14, this part of the pelvis is partly cartilaginous. The Y-shaped cartilage is so placed that the area of the base of the acetabulum is divided by a transverse line of cartilage into two equal parts, and the lower half is again divided by the horizontal line of the cartilage. In examining a patient, the natural extent of the cartilage should be considered, and the two sides should be always explored for the sake of comparison. In young adult females recourse should be had, at the same time, or exclusively, to examination per vaginam. The symptoms elucidated by a rectal examination have been—pain localized to the postcotyloid surface produced by pressure; enlargement of the intra-pelvic glands, thickening of bone; depression, flexibility, mobility, destruction or perforation of the post cotyloidean surface; congestion of the soft parts and pelvic abscess.—(*London Med. Record*, June, 1882.)

Reviews and Notices of Books.

On the Morbid Conditions of the Urine dependent upon Derangements of Digestion.—By CHARLES H. RALFE, A.M., M.D., Caius Coll., Camb., F.R.C.P., Lond., Assistant Physican to the London Hospital, &c., &c. London: J. & A. Churchill.

There is no doubt that more attention is given to the con-

dition of the urine as an indication of structural changes in the renal organs or grave disturbances in the circulation in other organs, than as demonstrating disordered clinical changes in connection with the processes of digestion and assimilation And yet, for a right understanding of what can be learnt from an examination of the urine, it is very necessary that we have a correct knowledge on these latter points. Their determination involves some of the most difficult problems of physio-chemistry. Dr. Ralfe lays before us in these chapters his investigations, which have extended over several years. They are given in good, clear language, the various points are well thought out, and the whole logically arranged. The book is thoughtful and philosophical, and well repays perusal. Any one becoming familiar with its details cannot fail to take a broader view of the general subject of dyspepsia in its various phases, and will no doubt be able to derive therefrom many suggestions which may come into practical service when similar matters are under his own observation.

A Manual of Obstetrics.—By A. F. A. King, M.D., Professor of Obstetrics and Diseases of Women and Children in the Columbian University, Washington, D.C. 12mo., pp. 317. Henry C. Lea's Son & Co., Philadelphia. 1882.

We confess to having opened this book with the question: "What possible necessity can there be for another work, large or small, on Obstetrics?" We reflected, however, that the necessities are oftener of the writer than the readers. The author tells us that it is designed for that much cared-for class of men, the students and junior practitioners. For them there is the most tender solicitude on the part of medical writers. The author claims little more than a compilation from the works of Leishman, Playfair, Lusk and other larger works, and an examination of his production certainly, in our opinion, furnishes for it a sufficient *raison d'être*. In describing the treatment of the stomach derangements of pregnancy, the author has omitted a remedy which we have found of signal value, namely, ¼ to ½-drop doses of Liq. Strychniæ, After the delivery of the placenta,

and having once more felt the fundus uteri to reassure himself that the womb is well contracted, the author says "the physician may leave the room while the nurse removes the soddened (?) blankets, etc., and cleanses the female, getting her ready for the binder," &c. Now, we do not think this is quite sound or safe advice to give to a student or junior practitioner. The safety of the patient will be much more certainly assured by watching the uterus and keeping up pressure over it for half-an-hour or more. Lives have been lost by a neglect of this precaution. The last chapter of twenty pages, on the Jurisprudence of Midwifery, is a novelty in works of the kind, but we believe it will be valuable. It is an excellent *resumé* of the medico-legal points connected with obstetrics. Altogether, we think the book will be very useful to students preparing for examination, and, perhaps, occasionally to the practitioner in a tremendous hurry. The latter, however, we believe, ought very rarely to content himself with looking into so small a book as this.

Extracts from British and Foreign Journals.

Unless otherwise stated the translations are made specially for this Journal.

Filaria Sanguinis.—Some months ago I called attention to Dr. Stephen McKenzie's case of hemato-chyluria. The patient, who was a young bombadier, was shown to the Pathological Society in October of last year. He then seemed in pretty good health, but every night his blood swarmed with embryo filariæ. It was calculated that somewhere about forty millions circulated in his blood nightly, while by day they entirely disappeared. It was found that by reversing his habits, by making him turn night into day, the filarial periodicity could also be reversed. How the embryos vanished, whether they were periodically destroyed or whether they lay hid in the pulmonary vessels, as Dr. Patrick Manson supposes, was a mystery, and a mystery it still remains; for all signs of the filariæ disappeared after a rigor from which the patient suffered three months before his death. The fatal result was due to exhaustion after double pleurisy, empyema, and cystitis. At the last

meeting of the Pathological Society a dissection of the thoracic and abdominal lymphatics from this case was shown. All the vessels were greatly dilated, and the thoracic duct was occluded for some distance. At the same meeting Mr. Shattock showed a beautiful specimen of adult filariæ, involved in a large clot in the right auricle of a human heart. The parasites projected from the clot in every direction, looking like long coiling strands of whipcord. The progress of our knowledge of this curious disease has been retarded by the fact that of the countries where it is most prevalent, in India it is difficult and in China it is well-nigh impossible, to obtain leave to make a *post-mortem* examination.—*Lond. Cor. Amer. Pract.*

Mitral Presystolic Cardiac Murmurs.—From a careful clinical study of the varieties, mechanism and clinical significance of mitral presystolic murmurs, in the *Amer. Journal of Med. Sciences*, Prof. Austin Flint draws the following conclusions:—1. There are two varieties of this murmur, which are distinguished by differences in quality and in mechanism. One variety is a rough, and the other is a soft, murmur. 2. The roughness in the first of these varieties is characteristic, and may be distinguished as vibratory or blubbering. The softness of the second variety is bellows-like, like other soft cardiac murmurs. It may vary in pitch and intensity, but, as a rule, it is low and weak. 3. The rough murmur is due to vibrations of the curtains of the mitral valve, caused by the passage of blood from the auricle to the ventricle. The soft murmur, like other bellows murmurs, may be due either to contraction of the orifice through which the blood passes, or to roughness of the surface over which it flows.

Death from Hepatic Colic.—Dr. Brouardel (*Annales d'Hygiene Publique et Medecine Legale*) reports a case of death apparently resulting from hepatic colic. A young woman, aged 30, apparently in good health, just before taking a railroad train drank a glassful of gooseberry syrup and seltzer and a few minutes after was seized by sharp abdominal pains. After some hours of alternate ease and pain the patient suddenly

died. On the autopsy nothing was found to indicate the cause of death except a large calculus in the ductus choledochus, sixty-one calculi in the gall-bladder, slight œdema of the duodenum and pancreas, and hæmorrhagic infiltration of the pancreas. Dr. Brouardel is inclined to refer the death to hepatic colic, but it is equally probable that the pancreatic infiltration might have produced it. This case is, however, in any event, not unique.—*Chicago Med. News.*

Resection of a Vertebral Body.—Dr. J. Israel (*Berliner Klinische Wochenschrift*, March 6, 1882,) reports a case of a scoliotic man who was paraplegic, and in whom the symptoms pointed to pressure on the motor portion of the cord. The presence of a cold abscess to the left of the first lumbar spine, the pain on pressure, and the fact that the paraplegia had gradually occurred, led to the diagnosis of caries of the body of the vertebra. The abscess was first opened next the sinus leading to the twelfth rib at its greatest convexity. The rib was found to be carious, and was resected. The vertebra had undergone cheesy degeneration, and was scooped out by a sharp spoon. The patient died thirty-seven days after the operation. On the autopsy, dry pleurisy and miliary pulmonary tuberculosis was found. The cases reported by Spencer (*New England Medical Monthly*), and that reported by *Gaillard's Medical Journal* for March seem to show the feasibility of this operation in similar cases to Israel's case.—*Amer. Med. Weekly.*

Local Application of Salicylate of Soda in Acute Rheumatism.—In the *British Medical Journal* of Jan. 7, 1882, p. 11, Dr. Charles Orton alludes "to a severe case of polyarthritis acuta in a young lady aged 19, where joint after joint became red, swollen, and exquisitely painful and tender." He tried "many local applications, besides internal remedies, without giving much relief," until he "applied lint soaked in a solution of salicylate of soda, under a cover of oil silk, to the affected joints. The relief was speedy and great." He has since tried it in a few cases in private practice with success, and is now using it more extensively, in cases under his care, in the North Staffordshire Infirmary.

CANADA

Medical and Surgical Journal.

MONTREAL, SEPT., 1882.

CANADA MEDICAL ASSOCIATION.

The Association met in Toronto on Wednesday, 6th September. The attendance was large, representatives being present from almost all parts of the country.

The President, Dr. G. E. Fenwick, took the chair at 10 A.M. After the report of the Committee of arrangements, past-Presidents Drs. Workman, Botsford, Canniff and McDonald took seats beside the chairman. The minutes of last meeting were read and approved. It was decided that the President's address should be postponed till the evening session.

Drs. Brodie of Detroit, and Elsburg and Goodwillie of New York, were elected members by invitation.

The President stated that Dr. W. B. Carpenter, of London, was in the city, and was willing to address the Association if invited. A deputation was therefore despatched, and soon returned, accompanied by Dr. Carpenter, who then gave a short address. He thanked the Association for the honour that was done him. He would say a few words upon the subject of general registration, which he understood was under consideration at the present time. His position as Registrar of the University of London, and the interest he had long taken in sanitary matters, put him in a position to speak with knowledge of the facts. In England they had a perfectly uniform system of registration, which had been first introduced in 1839, and later on into Scotland and Ireland. This system worked so well that he was satisfied that this entire Dominion should have some similar system of registration. The tabulation of statistics had been admirably worked out by Dr. Farr, to whom we owe so much. Dr. Farr

first used the word zymotic, although the same idea occurs in a work 140 years old by Sir John Pringle. Dr. Carpenter also spoke of the convertibility of one disease into an allied form by certain hygienic surrounding circumstances, and instanced the development of typhus from a mild remittent in soldiers confined in ill-ventilated ships. Sir R. Christison used to admit the possible convertibility of mild forms of fever to the severer types of typhus. One great point showing the value of a general registration such as he was advocating was to be found in the fact brought out in England that the mortality from all non-zymotic diseases was about the same throughout the towns and country districts, and that the excess of mortality in towns and cities was due entirely to the class of zymotic affections. He urged sanitary reformers to press these points upon the Government. It was always requisite, in matters of this kind, to arouse public opinion. This once accomplished, a great step had been made towards the desired end. It is necessary to keep constantly dinning these facts into the ears of the public that they may produce any effect. Sometimes the appeal to dollars and cents has more effect than any scientific argument. He alluded to the cholera visitation in Bristol, where the clean and dirty party were divided, and the leader of the latter was the chief sufferer. Canada has the same kind of battle to fight that England has had. England has won, and Canada will do the same if the leaders of public opinion are true to their principles. Dr. Carpenter also spoke of the importance of vaccination and the fact of the occurrence of the purpuric form of smallpox epidemically during the outbreak in 1871—a type which had not been seen since the end of the last century. The old inoculation system used to prevent this, because by it a mild form of the disease was always propagated. The virus must be renewed from time to time from the cow. He concluded a very interesting address by contrasting an ignorant people in old times, believing these diseases to be punishments from an offended Deity, with an enlightened people at the present day looking for a cause for that which they knew was only an effect, and then actively exerting themselves to counteract it. Acts, not prayers, are required. *Qui laborat orat.*

A vote of thanks to Dr. Carpenter was moved by Dr. Sweetland, seconded by Dr. Oldright, the mover remarking that these remarks by such a well-known man would help anew to direct attention to this important subject.

Dr. Fulton presented the report of the Committee on Necrology, in which the death of the following physicians throughout the Dominion during the past year was referred to :—Dr. Berryman, Toronto ; Dr. T. Mack, St. Catharines ; Hon. D. Brouse, Ottawa ; Dr. N. Fleming, Mildmay ; Dr. H. Parsley, Thornbury; Dr. J. A. Purney, Shelburne, N.S. ; Dr. A. Robertson, Liverpool, N.S. ; Dr. W. G. Middleton, Stella ; Dr. N. Munro, Brucefield ; Dr. McMichael, Gorrie ; Dr. G. Cook, Norwich ; Dr. J. Allen, Adolphustown ; Dr. J. B. Smith, Jerseyville ; Dr. G. Lount, Norwich ; Dr. A. J. Whitehead, Toronto ; Dr. W. Philp, Manilla ; Dr. H. H. Bouller, New Hamburg ; Dr. W. Wilson, Dorchester, N.B. ; Dr. J. P. Lynn, Toronto ; Dr. C. W. Heltz, Chester, N.S. ; Dr. A. R. Lander, Frankville ; Dr. W. Weir, Merrickville ; Dr. H. Yates, Kingston ; Dr. H. Orton, Ancaster ; Dr. McCay, Blairton ; Dr. Munro, Montreal ; Dr. F. H. Wright, Toronto ; Dr. H. Bingham, Manilla ; Dr. A. McKay, Beaverton ; Dr. G. W. Campbell, Montreal ; Dr. Maxwell, Bear River ; Dr. McIlmurray, Toronto ; Dr. H. W. Lloyd, Coldstream ; Dr. H. E. Bissett, Hawkesbury ; Dr. T. Blackwood, Pakenham ; Dr. J. Salmon, Simcoe ; Dr. A. Greenlees, Toronto ; Dr. R. H. Wight, St. John's, Que.

Dr. Graham (Toronto) read the report from the Committee on Medicine. He confined himself chiefly to a discussion of the recent discoveries of Prof. Koch and others concerning the bacterial origin of tubercular disease. The immense importance and the practical bearings of these operations were specially dwelt upon. At the conclusion, Dr. Graham exhibited a specimen from a phthisical lung which he had brought from Germany.

The following gentlemen were appointed a Nominating Committee :—Drs. McDonald of Hamilton, Kennedy of Toronto, Sweetland of Ottawa, Rodger, Cameron and Robillard of Montreal, and Botsford of St. John, N.B.

Medical Section.

The Medical Section met at 7.30 P.M., Dr. McDonald (Hamilton) in the chair.

The Chairman briefly addressed the section upon the importance of State Medicine, alluding to the labours of Dr. Carpenter in this direction and to the difficulties which are experienced in a new country in laying the foundation of a system of general registration and supervision of hygienic matters. Canada is peculiarly difficult to manage in this respect, owing to the great distances between its various parts. The public, too, are now so generally educated, that it is necessary for us to give our reasons as well as our opinions. All these questions, therefore, should be very fully discussed by the profession.

Dr. J. C. Cameron (Montreal) then read a paper upon *Axis-Traction*. He contended that the general principles of axis-traction was fully admitted, and that the only question to be decided was the form of instrument best calculated to carry this out. He believed that the forceps of Tarnier was that which best served this object. The best is that which does least injury to mother and child, is safest, and *ceteris paribus* is least fatiguing. The different forms—simple curve, double curve, and axis-traction—were contrasted. The Tarnier forceps has certain advantages, viz. (1st), it allows of axis-traction; (2nd) it indicates the movements of the head and the proper direction for traction; and (3rd) allows mobility of the head. The objections which had been raised were: 1st, Clumsiness and difficulty of application. 2nd, Injurious compression of the head. 3rd, Difficulty of disinfection. 4th, Danger of wounding the soft parts. Dr. Cameron, after discussing these points, said that from a use of the instruments he thought that two things specially would strike one who employed it for the first time, viz., the great backward traction one had to make, and the wonderful ease with which the head advanced in that line. He advocated its more general employment for the high operations.

Dr. Holmes thought we should use every aid to delivery, especially considering the frequency with which lacerations of the cervix are now found to occur. He followed the leverage

plan of Dr. Albert Smith. By watching the motion of the head we got the right direction for the traction. Dr. H. believed that ruptures often occur from encouraging a woman to bear down just at the time when she should not do so—*i.e.*, just as the cervix and the perineum respectively are being passed.

Dr. Temple would on no account use Tarnier's forceps exclusively. He criticised one of the diagrams showing the Carus's curve, for the head really enters in a straight line, and continues so till well back against the sacrum before any curved direction is communicated to it. He believed that the double curve of the forceps gives the necessary traction backwards in the direction of the axis of the inlet. He thought the Tarnier forceps may outdo the double forceps in occipito-posterior presentation, but not the simple forceps ; the latter, in these difficult cases, is the safest and surest, and least liable to slip. He did not think that the pressing back of the perineum was so injurious as represented (in using the straight instrument), because the parts were so very relaxed and movable. He would not trust Tarnier's instrument except to a skilled hand.

Dr. Stewart mentioned that he had seen two autopsies in Vienna, both from rupture of the vagina following delivery by means of Tarnier forceps. The obstetricians in charge (Braun's assistants) had never met with the accident before with other instruments.

Dr. Alloway read a paper on the *Immediate use of the Uterine Scoop in the treatment of Inevitable Abortions.* He drew attention to the fact that the use of the scoop had not been alluded to in any of the text-books on obstetrics of recent publication. He said he had used it in 24 cases within the last three years ; some of these cases had been subjected to an extreme state of anæmia from exhaustive hemorrhage, and some were found suffering from septicæmia from the retention of decomposing secundines before he had been called to see them. He contended that the use of the tampon had been abused ; that it was not justifiable to allow a woman to remain bleeding for days, relying upon the tampon to check hemorrhage and cause expulsion of the retained secundines, when we could completely empty the

uterus with the scoop directly the cervix was sufficiently dilated to admit the finger, without giving pain to the patient or causing injury to the parts. Dr. A. condemned the use of the placental forceps as being an unsafe instrument. He uses the scoop with the patient on her left side, and gently separates the adherent parts from the uterus; doing this by the forefinger was in many cases impossible, unless the operator possessed a finger of at least six inches long.

Dr. Tye would rather use a scoop with some feeling at the end of it. A good plug causes both descent of the uterus and also dilatation. He did not think the scoop would be wanted once in a great many cases. He would fear leaving some of the contents behind except he had explored by the finger, thus risking septicæmia, and would not multiply instruments.

Dr. Rodger could not agree to condemn the tampon, but thought that the fault lay in the bad way in which it is often applied. When properly applied it arrests hemorrhage and causes dilatation of the cervix. He would fear that the scoop might do harm, and possibly cause injury to the uterus or secondary hemorrhage.

Dr. Harrison (Selkirk) had often wished for something to loosen the ovum, and, instead, had been obliged to plug and wait. If the scoop be simple, safe, and easy to use, then he was very glad to hear of it.

Dr. Bray advocated the tampon; he always succeeded with it in a reasonable time. He would fear possible injury from the scoop.

Dr. Temple argued in the same direction, and spoke of the care that should be exercised in plugging.

Dr. Sloane uses the alum-egg. Since adopting this method he never fears hemorrhage, trusting patients to it even at a considerable distance.

Dr. Holmes thought there were objections both to the scoop and to the tampon, against which we must be careful to guard. The scoop is not certain to remove everything, and may cause injury. With the plug, hemorrhage may continue and septic symptoms may be caused. To prevent the former you must plug

with care ; the second, see that the plug does not remain too long.

Dr. MacDonald said that we must consider the manipulative skill of the operator. In some hands, the scoop might be quite safe. The convenience of the surgeon may sometimes be an argument in its favour. He always uses the plug and the finger. He thought the danger of septicæmia from retained secundines rather exaggerated.

Surgical Section.

This section met at 7 P.M. Dr. Grant, of Ottawa, occupied the chair.

Dr. Roddick asked permission to exhibit a patient who had suffered from a most aggravated form of spasmodic torticollis, but who, it would be seen, was now perfectly well. The history of the case is briefly as follows :—Henry O., aged 38, began to complain about March, 1881, of a twitching of the right sterno-mastoid, the head being jerked to the left side. He consulted Dr. Hammond, of New York, who prescribed faradization and atropia hypodermically, but without permanent benefit. When he came under Dr. Roddick's care in October of the same year, the patient was obliged to hold his head constantly between his hands, and it was absolutely impossible to straighten the head, and the spasms were most violent. Dr. R. P. Howard saw the patient in consultation, and advised a continuance of Dr. Hammond's treatment, with the addition of bromide of soda internally. There being no improvement at the end of a month, the right sterno-mastoid was divided subcutaneously, Dr. Geo. Ross concurring and being present. A marked improvement in both the position of the head and violence of the spasms followed the operation; but after a month the symptoms relapsed, and the patient became nearly as bad as before. The question of nerve stretching was now debated, but before resorting to this it was decided to try the application of the actual cautery over the cervical region of the cord. This was thoroughly done, poultices being subsequently applied. The improvement was most marked so that in a week the patient could sit up in a chair, holding the head by one hand only. A second applica-

tion of the cautery was made after a month, and from that time the symptoms rapidly disappeared, until June last, when he resumed his occupation of tinsmith. Nothing but tonics in the shape of internal treatment were given to the patient after the actual cautery was first applied.

Dr. George Major, of Montreal, then read a paper on "Laryngeal Rest."*

Dr. Ryerson agreed with Dr. Major that laryngeal rest was most essential, especially in acute inflammation. He had recently put the larynx at rest by performing tracheotomy in a case of tumor of the left ventricular band, and the result was most gratifying.

Dr. Elsberg, of New York, who was received with applause by the section, said that he had jotted down a few notes, but he had been anticipated in everything by the reader of the paper. He believed rest to be one of the most important therapeutic agents in the treatment of all throat affections. He stated that the practice of gargling the throat was very injurious by disturbing the parts, and that he preferred the application of remedies by other means, as by painting the part or by spray. He advocated tracheotomy in severe inflammation, in ulcers especially syphilitic and malignant, and in the case of morbid growths. He reviewed the physiological functions of the larynx, and showed how thoroughly the organ could be put at rest by the operation of tracheotomy.

Dr. Hingston doubted the efficacy of tracheotomy in malignant disease, as he did not think it retarded the progress of cancer, and certainly did not cure it.

Dr. Fenwick did not think that any one would dream of curing malignant disease by tracheotomy, but knew from his own experience that both it and colotomy were useful in retarding the progress of malignant disease of the larynx and rectum respectively. He was a strong advocate of physiological rest in all such cases

Dr. Goodwillie had performed tracheotomy frequently, and always preferred the gold tube advocated by Dr. Major.

* This paper will be published in a subsequent number of this JOURNAL.

Dr. Sutherland, Curator of the Pathological Museum, McGill University, then presented the following catalogue of a series of specimens on exhibition, illustrating the terminations of aneurism:

I. Aneurismal dilatation of left vertebral and first part of basilar arteries. Rupture.

J. B., man æt. 36, found dead in his bed. Had had a hard chancre, followed by severe secondary symptoms, but had completely recovered. Microscopical examination of the diseased arterics showed no special features warranting the conclusion that the process was syphilitic.

II. Aneurism of left middle cerebral artery.—Old apopletic cyst.

Patient æt. 55, ill for over eighteen months with obscure cerebral symptoms.

III. Aneurism of right middle cerebral artery.

Woman, æt. 40 ; good family and personal history. Said to have been beaten about the head by her husband.

IV. Aneurismal dilatation of branches of the pulmonary artery on the walls of phthiscal cavities.

Man, æt. 44, with phthisis, died unexpectedly of hemorrhage from the lungs.

V. Aneurism of right iliac artery and atheromatous abscess.

Taken from an old woman who died of cancer of the cardiac end of the stomach.

VI. Aneurism of the hepatic artery.—Death due to suppurative hepatitis.

Man, æt. 21, admitted into Hospital with symptoms of abscess of the liver. Personal and family history good ; temperate habits. Never had dysentery, piles, nor any abdominal or rectal trouble of any kind.

VII. Aneurism of aorta.—Rupture into the esophagus.

Woman, æt. 55, ailing for some days with dyspeptic symptoms. One evening on going to stool she complained of feeling sick, did not vomit, fell over suddenly, and died in a few minutes.

VIII. Aneurism of aorta.—Rupture into left pleura.

Man, æt. 43 ; accustomed to heavy exercise. First definite symptoms of heart trouble seven or eight years before death. Treatment—Absolute rest, and *very* large doses of Potass Iodid for nine weeks.

IX. Aneurism of aorta.—Rupture into the trachea.

F. J., a negro; cough severe and continuous, sometimes paroxysmal—of a hoarse, croaking character. Signs of aneurism well marked.

X. Aneurism of aorta.—Death from exhaustion.

E. H. Harsh, croaking cough ; usual symptoms of phthisical disease.

XI. Aneurism of abdominal aorta, shewing deposit of fibrinous laminæ.

XII., XIII., XIV. Aortic aneurisms, shewing nature's cure.

Dr. Shepherd then read a carefully prepared and exhaustive paper on the subject of "*Cervical Ribs.*" He described three cases which had come under his notice. In the first case, the supernumerary rib occurred on the left side, and articulated with

a process growing from the 1st thoracic rib. The second case was that of a skeleton belonging to Dr. Roddick, in which each side of the 7th cervical vertebra carried a supernumerary rib. Each rib floated freely anteriorly. The third case occurred in a patient in the Montreal General Hospital. The cervical rib was in the right side, and floated freely. Dr. Shepherd stated that these ribs were homologous with the cervical ribs of crocodiles and the anterior transverse processes of birds. In cases where the subclavian artery passed over the rib, they were sometimes mistaken for aneurism, and in others for exostoses. The literature of the subject of cervical ribs was noticed, and their morphological significance dwelt on.

Dr. Shepherd also demonstrated his method of strapping "caked breast." This was fully explained by him in a previous communication to this JOURNAL.

Dr. Grant, of Ottawa, reported a case of "Paget's Disease of the Breast," which will also be published later on.

Dr. Hingston had not seen a similar case to that reported by Dr. Grant, but he had recently amputated a leg in a case of great hypertrophy of the tissues following long continued eczema.

Dr. Roddick thought he had seen a case of Paget's disease. The patient refused to have an operation performed, but he heard that she subsequently died of internal cancer. He had seen a case of epithelioma of the ear follow an incurable eczema of the external auditory meatus.

Dr. Fenwick had never seen a case of Paget's disease, but had seen cancer implanted on an old burn, and believed that many long continued cases of irritation may, in certain subjects, be followed by malignant disease.

Thursday, 7th September.

GENERAL MEETING.

The minutes of the last meeting were read, several new mem-members were elected, and

Dr. Shepherd read the report from the Committee on Surgery. The first point was a description of the more recently-advised methods of carrying out antiseptic wound-dressing by means of dry-dressing, pressure, iodoform, &c., in place of Listerism,

which he defined as the procedure by spray, gauze, McIntosh, &c. He then referred to the great advances in abdominal surgery, such as extirpation of the spleen, the pregnant uterus and kidney, and resection of the stomach by Billroth. On transplantation of bone, the writings of Dr. McEwen were particularly alluded to; also Hamilton's treatment of ulcers by sponge-grafting. Some space was given to the operations for the relief of club-foot, the writer stating that tenotomy of the Tendo-Achillis should be made secondary to that of the tibial muscles in Talipes Equino-Varus.

Dr. Canniff congratulated Dr. Shepherd upon the excellence of the report, and concurred with him in his views on antiseptic dressings other than Lister's.

Dr. Grant considered the report very satisfactory. He alluded to the investigations of the great Pasteur with reference to the germ theory. He regretted to inform the meeting that this great man had quite recently suffered from an attack of paralysis. Observations on the line adopted by Pasteur were absolutely necessary for furthering our knowledge of this important subject. Antisepticism is the important matter in surgery, no matter how carried out, and it was well to become familiar with all the different ways of practicing it. The scientific procedures of bone transplantation and sponge-grafting showed great advance in our knowledge of means of remedying disabilities.

Dr. Roddick considered the report comprehensive, concise, and with good points made. He was not a convert to dry-dressings. The success in his hands of the introduction of Listerism into the Montreal General Hospital had to the present time remained so gratifying in all cases of large wounds, amputations, excisions, &c., that he had not yet been able to see any good reason for adopting another system. He mentioned that the disciples of Lister were only now recovering from the blow given the system last year by the celebrated Dr. Keith of Edinburgh. It was not generally known that Dr. Keith used a spray of 1 to 30, whereas Lister himself had cautioned him to employ a very much weaker one. He (Dr. Roddick) uses in ovariotomy 1 to 80. He had recently performed nephrotomy in an advanced

case of suppurative disease with an immediately gratifying result, but death followed from the same disease in the other kidney. With reference to club-foot, in most cases of talipes equino-varus, he thought division of the Achilles tendon was alone required to correct the deformity, because of the tendon being so constantly found inserted into the inner border of the os calcis. He did not divide the tibial tendons, and had followed this practice in all cases for the last three or four years.

Dr. Hingston found the report remarkably careful, truthful and without bias. Real antisepticism is true surgical cleanliness. He does not now have erysipelas in the Hotel Dieu Hospital. He had used both Listerism and non-Listerism, and succeeded best with the simplest procedures. He had a fatal case of ovariotomy lately, where he believed the result was due to the use of carbolic acid. In talipes, he operates very early and leaves the Achilles tendon to the last. In one case he followed the example of Dr. Phelps, dividing all the structures and applying a weight to the foot.

Dr McKay of Woodstock favoured treating club-foot without tenotomy, stretching the tendon and putting on a plaster bandage.

Dr. Sloane spoke of the advantage to the country practitioner of the use of carbolic acid. He now confidently treats a compound fracture with lint soaked in a solution of the acid in glycerine.

Dr. Ferguson of Toronto knew that Dr. Keith used solutions of 1 to 30, sometimes stronger. He had seen his practice in Edinburgh. Dr. F. thought, and knew it to be the general opinion there, that he pushed it too far.

Dr. Stewart said that Keith had 80 consecutive successful cases—better success than any other operator—before he gave it up. Keith's chief reason for abandoning it had been his suffering from hæmaturia himself. This was probably owing to some idiosyncracy.

Dr. Canniff said that in the Toronto General Hospital they were not all Listerites, but were all in favour of antisepticism in some form. Their mortality was very creditable. Too much credit was perhaps given to Lister alone. The honours must be shared with Pasteur, Gamgee and several others. The enforce-

ment of the principles of rest and pressure by the latter was of the greatest importance to surgeons.

Dr. John Campbell said Lister did not always use the spray. If the wound was already septic it was not used. Lister said in his hearing that he did not invent the spray: he adopted it from others.

The President said that he could be called a Listerite. He found very good results in certain cases of fœtid wounds by purifying them with chloride of zinc and then applying Lister's dressing—*e.g.*, in fistulæ from sequestra. He will continue the use of the spray until he can get something better. Some points raised by Dr. Hingston were hardly fair, as the comparison of Syme's amputation with excision of the breast. The former nearly always suppurated, no matter how treated; the latter often healed by first intention, without any special dressing. Listerism carries out rest by means of the numerous plies of thick gauze which it involves. He had used the dry dressings of Gamgee, and had not been satisfied with it.

Dr. Shepherd, in reply, said that Lister himself had advised Keith to give up the spray. He thought that in dry dressing a great advantage was, that you do not require the drainage-tubes that Listerism needs; there was not so much serum poured out, and the careful adjustment prevented the collection of the fluid. A tube will keep up discharge by its mechanical irritation, and a wound often closes rapidly after removal of a tube. Dr. Duncan of Edinburgh gives cases of Syme's amputation healed by first intention. Chiene aims at dry dressing: he has already discarded the McIntosh. He (Dr. S.) thought iodoform was much superior to carbolic acid as an antiseptic; it is much more persistent, thus you do not require to renew the dressings as you must do pretty frequently with ordinary carbolic acid solutions. He often left iodoform dressings for a week without change, and without any unpleasant odour. It is objectionable if the surface to be dressed be very large. Prof. Esmarch had 398 major operations, of which 85 per cent. required only one dressing, and in 15 per cent. only one removal. Dr. Shepherd believed that Keith used the regular strength. Some club-foot cases can be treated by mani-

pulation alone. In others he thought the tibial tendons must be divided. Dr. Sloane, who had alluded to compound fracture, was following the plan of the late Dr. Callender—carbolized oil in lint was applied, and then at intervals layer after layer of the same. It was left for a month without change. The simpler all dressings are the better.

Dr. Tye read the report of the Committee on Therapeutics. He alluded to the revival of the use of Static electricity by Charcot and others: many of the difficulties in the way of its employment had been overcome. It had now been used successfully in contractions, chorea, anæsthesia, and some of the forms of neurasthenia. Some have found it useful after the other forms have failed. Galvanism of the brain has also received considerable attention. It is an agent of great power, and requires to be used cautiously. It has proved useful in diabetes inspidus, in melancholia, and in some cases of auditory delusions. With reference to jaborandi and pilocarpin, the chief practical point is its possible value in diphtheria. In spite of the recommendations of Guttmann, it has proved to be a hazardous agent owing to its depressing action, and the most recent results are not reassuring. The therapeutic uses of ergot are not exhausted. The latest is in pertussis. It is claimed that the disease is cured by it in from one to three weeks. Nitro-glycerine in a one per cent. solution, is undoubtedly valuable, especially in angina-pectoris and some other heart affections, and sometimes proves reliable when digitalis has failed. Salicylic acid still maintains its high place as a therapeutic agent. The treatment of phthisis by antiseptic inhalations has been exciting great attention. The continuous inhalation, specially as recommended by Dr. Hunter McKenzie of Edinburgh, is that which is really curative. He recommends, above all others, a mixture of three-fourths of kreasote and one-fourth of carbolic acid. The arrest of the septic symptoms is very marked. The treatment is sure to become popular both with the profession and the public.

On motion of Dr. John Campbell, seconded by Dr. Stewart, a vote of thanks was given to Dr. Tye.

Medical Section.

The section met at 2 P.M., Dr. McDonald in the chair.

Dr. Harrison (Selkirk) read a paper on "*A peculiar form of Fever.*" The first case—a child—began with a remittent fever, looking like typhoid at first; in two weeks it became distinctly intermittent; subsequently there occurred convulsions, opisthotonos, sordes on teeth, &c. Died of exhaustion. The second case was somewhat similar at first, having, later on, strabismus, hebetude, and opisthotonos. Recovered in ten weeks, but was not strong for twelve months. The third had also a remittent, follow by intermittent type of fever and an eruption of small red spots, finally dullness, involuntary evacuations, emaciation, and bed-sores; died in 13 weeks. The fourth case lasted four weeks and recovered.

Dr. George Ross thought that the meeting had not sufficient evidence before it to be able to discuss with benefit the clinical cases brought up by Dr. Harrison. It was really a question whether they belonged to any specific form of fever. The febrile phenomena might have been only one part of their actual pathology. Such irregular febrile conditions as observed in these cases are met with in various very different kinds of disease, such as septicæmia from obscure deep-seated suppuration, in acute tuberculosis, and in ulcerative endocarditis. We had no post-mortem evidence before us, and therefore, for anything we could say, the cases reported might have belonged to some such category as the above.

Dr. Tye had seen 27 cases similar to those of Dr. Harrison's. They considered it to be a form of cerebro-spinal fever.

Dr. Holmes said that, being endemic, it could not belong to such conditions as suggested by Dr. Ross. He had seen a large number of cases, and thought them of the nature of cerebro-spinal meningitis. They were not malaria.

Dr. Mullin then read a paper on "*Diphtheria.*" He dwelt upon the importance of correct diagnosis, and alluded to the special form of exudative tonsillitis which so often prevails in a family; in these cases the early symptoms were generally much more severe than in the average of cases of diphtheria. If local

means can serve to modify the disease, then we can postpone operation till as late as possible, to give them an opportunity to act, and *vice versâ*. Amongst the important local applications stand sulphur, sulphites, salicylic and carbolic acids, kreasote, pepsin, chloral and lactic acid. He believed both steam spray and syringing to be useful. Had not had success from solvents. There are many midway cases between those certainly fatal and those which recover of themselves to make us use every effort to combat the disease. It probably resembles syphilis and vaccinia ; local means alone cannot prevent any of them.

Dr. Holmes read a paper on "*Cholera Infantum.*" He dwelt specially upon the etiology of the disease, the greatest factors being persistently heated atmosphere, too warm clothing, and indigestible food. Indications for treatment being the withdrawal of heat by frequent cold sponging, a large airy room, and controlling the diarrhœa. No astringents should be used during the early stages. The castor oil treatment is much better. Later on, minute doses of bichloride of mercury gave good results.

Dr. McDonald agreed with the condemnation of astringents, the use of which was common practice. The only hope for these cases in the cities was to get them away to the country, where they could get the necessary coolness and pure air.

Dr. Stewart read a paper upon "*An account of three cases of Sciatica and one of Painful Stump treated by stretching the Sciatic Nerve.*" The success met with from this practice had been very gratifying. (The paper will appear in this JOURNAL.)

Dr. Geo. Ross congratulated Dr. Stewart upon his results. Dr. Stewart was, he thought, the first in this country to adopt this heroic procedure in these cases. Dr. Ross had only seen one sciatic-stretching—this was for tetanus,—but though giving some temporary alleviation, the patient had subsequently died.

Dr. Stewart said, in reply to Dr. Workman, that the value of nerve-stretching had been accidentally discovered by Billroth. He had a case in which neuroma was suspected ; he cut down and explored for it, dragging about the nerve in doing so ; no neuroma was found, but the pain was removed, and six months after Nussbaum of Munich first operated in this way.

Dr. Prevost of Ottawa read a paper upon "*A case of Tumour of Bones of Skull pressing on Brain.*" A very large malignant growth had commenced in the anterior and lateral part of the skull, and produced great pressure backwards upon the brain before any symptoms were shown. The skull and brain were exhibited. (The paper will appear in this JOURNAL.)

Dr. Shepherd enquired whether there was any history of injury. He spoke of the remarkable degree to which the brain could sometimes be mutilated without proving fatal, and instanced the celebrated Boston crowbar case and others.

Dr. Prevost said there had been no injury and no other assignable local cause.

Dr. Cameron of Toronto exhibited a well-marked case of Pseudo-Hypertrophic Paralysis. The patient was a boy of 11 years of age. There was no family history of the disease; had been well till three years old, when gradual loss of power was observed, and the muscles of the calf of the leg began to enlarge. He now presents the characteristic features, with decided lumbar curve and great enlargement and hardness of the calves. When lying upon his back, he cannot rise unaided; when stooping down, he raises himself by climbing up his legs. Had taken cod liver oil, arsenic and iron without success.

Dr. Temple mentioned a case under his care which was remarkable, because the man was 64 years old. The earliest symptom was severe sciatic pain, nine months ago. The progress was slow, but now the right calf measured $3\frac{1}{2}$ inches bigger than the other, and was very hard. It is confined to the right leg, and gives him a peculiar gait.

Dr. Taylor said this case seemed to show that this disease and progressive muscular atrophy are the same disease, as he believed was the case. In this disease some of the bundles were atrophied, and in progressive atrophy some bundles were found hypertrophied. He held with Charest, Friedreich, Bristowe and others, that it was of myopathic origin, because the muscular change was always found uniformly the same, whilst the lesions in the nervous centres were very various in different cases—*i.e.*, as regards their location.

Dr. Osler pointed out one special symptom, muscular fibrillar tremor, which characterized the atrophic disease, and was not present in hypertrophied paralysis.

Dr. Cameron thought this should not be considered pathognomic, and said they were to a slight extent present in this case.

Dr. Graham believed the pathology to be, first, a sclerosis, and, secondly, a change in the muscles.

Dr. Sheard had recently examined a case *post-mortem*. He found the anterior horns in the upper part of the cord healthy, but with signs of inflammation around them. As he passed down the cord, these began to show fatty change, and lower still this process was present in a marked degree. A pathologicht principle was that fatty degeneration followed inflammation, *e.g.*, in fatty change in the liver and other organs, and this fact was very suggestive in the present case.

Dr. Black read the report of "*A case of Echinococcus disease of the Lung.*" The disease had begun in the liver, lasted for some years, suppurated and burst into the lung. It also involved the spleen. The specimens were shown. (The case will appear in this JOURNAL.)

Dr. Osler said that there were only five cases in America of this disease affecting the lung. Involving the lung alone was very rare. Dr. Ellis of Boston reports one such of four years' duration; death occurred from suppuration of the cyst. If the cyst do not suppurate, it may last for years, and show no bad symptoms; but with suppuration comes general disturbance and general sepsis.

Dr. Metcalf showed a good example of spontaneous cure of hydatid cyst of the liver, the walls having been converted into a shell of firm chalky or bony matter.

Dr. H. P. Wright read a paper on "*A case of Phantom Pregnancy.*" A woman, æt. 38, had had two natural confinements; was quite regular, but suffered from some pain and distension at the time. There was no hysteria. In October, 1880, had an attack of pelvic cellulitis; subsequently, thought she had an early miscarriage. Some time after this menstruation ceased for a time, and the breasts and nipples enlarged, then quicken-

ing was thought to have occurred, and distinct movements were observed and could be plainly felt. At full term, no sign of labour. One month later on, being anxious, Dr. W. was called in and found a large abdominal tumour, the seat of violent, irregular jerkings, which were sometimes accompanied by pain. The girth was 46 inches. On examination, the uterus was found normal in situation and dimensions. A fœtal pregnancy was suspected. Nothing further transpiring, and the movements continuing, a further examination with Dr. Sweetland resulted in a diagnosis of fibroid tumour. Finally it was decided, on the suggestion of Dr. Osler, to give chloroform. This having been done, the tumour entirely disappeared. She is now quite well, having been treated by tonics and antispasmodics. The condition was plainly irregular, painful, muscular spasm. Anæmic states probably dispose to this trouble. Dr. Weir Mitchell gives a remarkable case of phantom tumour of the left pectoral muscle. Dr. Wright snggests that in certain nervous states the compression of nerves between layers of flat muscles may keep up the irritable state necessary for the production of phantom tumour.

Dr. Sloane had met with a case of this kind. The diagnosis had been easy, because the entire tumour had been tympanitic.

Dr. Geo. Ross had reported a case referred to by Dr. Wright. So far had it gone in this case that arrangements had been made to operate upon what was supposed to be an extra-uterine fœtation. Under ether the diagnosis was made at once. The patient could not be disabused of the idea that she was pregnant.

Dr. Ellis read a paper on "*The Chemical Composition of Milk from Distillery Cows.*" The result of the analysis showed that this class of milk contains more fat than others, the remaining solids being about normal. He was not prepared to say whether this kind of food produced any morbid condition of the cow.

A communication was read from Dr. Slayter of Halifax, showing the advantages of that city as a health resort.

The section then adjourned.

Surgical Section.

The section met at 2 P.M. Dr. Grant in the chair.

Dr. Gardner, of Montreal, read a paper on a "*Rare Form of Uterine Tumour*," which will also be subsequently published.

Dr. Hingston's paper on "*Certain Obstructions in the Air Passages*" was next in order. The reader first related two cases of foreign body in the nares, which had caused unusual symptoms, and then proceeded to give the notes of a case of impacted artificial tooth in the trachea. He first attempted to dislodge it by inverting the patient, but failed. The symptoms becoming urgent, he performed tracheotomy, assisted by Drs. Fenwick and Major, and succeeded in catching the body with a curved forceps. The patient subsequently did well.

Dr. Major, who was the first to discover the body with the laryngoscope, described its exact position. He thought that if a pair of forceps had been introduced through the larynx while the patient was in the inverted position, the foreign body might have been caught and withdrawn.

Drs. Harrison and Fulton related cases of foreign body in the larynx in which tracheotomy had been performed.

Dr. Roddick asked Dr. Hingston whether in a similar case, being assured of the presence of a foreign body, he would not prefer to resort to tracheotomy at once, or before attempting other devices for its removal. He thought that great and permanent injury to the soft parts of the larynx would be almost certain to follow the dragging through of so irregular a body as that on exhibition. He thought also that the wound in the trachea should never be closed by suture after tracheotomy in these cases, but should be left to close of its own accord.

Dr. Fulton then read a paper on "*Polypoid Fibroma of the Bladder*." This occurred in a child one year and eight months old. When a year old the child began to complain of symptoms of stone, but nothing of the kind was ever discovered. Pus was found in the urine, and on one occasion a small piece of the polypus was passed, which was the means of clearing up the diagnosis. The child died suddenly from rupture of the bladder. The specimen was shown to the section.

Drs. Ferguson and Hingston thought that an earlier diagnosis might have been made, if a portion of the tumour had

been withdrawn by means of lithotrity forceps, and examined microscopically.

Dr. Ryerson read a paper on "*Polypus Nasi*," in the treatment of which he preferred the snare to the forceps, and strongly advocated glacial acetic acid as a local application.

Dr. Walker next presented a paper on "*Modern Lithotrity*," reporting several cases on which he had operated.

Drs. Saunders, Hingston and Roddick related their experience in the operation, the two latter speakers being rather opposed to it excepting in certain cases where the calibre of the urethra was large and the stone soft.

Dr. Goodwillie, of New York, explained, with the aid of diagrams and wax casts, "*A New Operation for Closure of Harelip and Hard Palate immediately after Birth.*" He showed the instruments employed for breaking down the bone, and also a very ingeniously constructed clamp-suture for keeping the edges of the parts in apposition.

Dr. Reeves exhibited a number of photographs and morbid specimens, and read a communication on "*Affections of the Orbit and Frontal Sinus.*"

Dr. Fenwick made a few practical remarks on the subject of knee joint excision, and showed a number of photographs of cases and dry preparations of bones, which were much admired by members of the section. He explained his method of making section of the articular ends of the bones in the operation of excision of the knee joint, and the antiseptic method of dressing. He stated that twenty-six excisions of this joint had been performed in the Montreal General Hospital, of which number two had died and two required subsequent amputation. Of the deaths one could be attributed directly to heart disease. He mentioned that in the case of children the diseased cartilages were pared off by means of a strong knife, instead of the saw, the idea being to sacrifice a minimum quantity of bone and to disturb the epiphyses as little as possible.

Dr. Ferguson reported three cases of Eczema treated by the internal administration of the viola or wild pansey and conium baths. The results had been very satisfactory.

Dr. Cameron, of Toronto, exhibited a man whose thigh had been dislocated backwards and ileum fractured some six months ago. He was still very lame, and it was thought that the dislocation had never been reduced. The second case was one of ununited fracture of the femur; and the third a girl aged about twenty, who suffered from an enormous recurrent tumour of the upper jaw. As the soft parts were all involved, it was thought that no operative interference would be justifiable.

Friday, 8th September.

GENERAL MEETING.

The minutes of the last meeting were read and approved.

Dr. Worthington read a special report upon malaria, which properly formed part of Dr. Botsford's report on Climatology and Public Health. It consisted of an enquiry as to the localities in Ontario affected by Malaria, the physical character and climate conditions of these sections, and the effect of these conditions on the public health. It enquired also into the extension or repression of this disease—the fatal and non-fatal forms of malarial poisoning—and raised the question of how far malaria was responsible for favoring a fatal termination in other diseases, and finally what remedies best combat it. (The report will be published later in full.)

Dr. Oldright said that the Ontario Government had already requested the Ontario Board of Health to institute investigations into the matter, especially in Skoubekonk region. Malaria in some places is undoubtedly increasing. Some of Dr. Worthington's hints have already been anticipated, and will be practically carried out. In some of the States also, as New York and Massachussetts, malaria was on the increase. The Boards of Health in several States are investigating the subject and carrying on enquiries as to its etiology upon an extended scale.

The report of the special committee appointed last year to devise a comprehensive scheme for the collection of Vital Statistics was then read by the Chairman, Dr. Canniff. (This report being very lengthy, is held over for publication in next issue.)

The following resolutions were then moved by Dr. Playter and seconded by Dr. Roddick :—

1st, That for the present the sanitary statistics shall be confined to the cities and larger towns in the Dominion, such to be published monthly, and the deductions to be drawn therefrom to be circulated in the various centres specified.

2nd, That for future guidance in sanitary matters, a commission should be appointed by the Dominion Government in order, by consultation and co-operation with the various local governments, to arrive at some common basis of action in carrying out such sanitary measures as may be necessary for the guidance of the Dominion Government.

3rd, That such commission shall consist of at least two or more medical men, with a legal adviser, whose duty it shall be to examine carefully into the various requirements of such action in sanitary matters.

The President said that in England, mortality statistics alone were obtained. Disease statistics are not necessary, could not be obtained with accuracy, and should not be attempted.

Dr. Oldright quoted Dr. Lyon Playfair as saying that the deaths showed like wrecks along the shore after a storm, whilst diseases served as warnings of an impending hurricane. In England, movements of this kind progressed but slowly ; in the United States they went on more rapidly. They have already established something of this kind in Ontario, and the profession is found willing to help it on. Very few medical men applied to have refused to keep the necessary records. The movement ought to extend throughout the Dominion. Dr. Oldright moved, seconded by Dr. Worthington, that the words " cities and towns" be omitted.

Dr. Grant said that the $10,000 which had been voted was but a small sum, but that it would be sufficient to make a beginning in the cities and towns. He thought that afterwards other parts would be anxious to follow.

Dr. Ferguson opposed limiting operations to cities and towns. He thought the whole country was interested in the movement,

and that all the agricultural districts should come within its operation.

Dr. Playter advocated a Commission of Public Health. He divided statistics into three parts. 1, Vital statistics, consisting of Births, Deaths, and Marriages. This is not under the Dominion Government. 2, Statistics of Infectious Diseases. This was carried out by municipalities in England. 3, Statistics of General Disease. This is of much less importance. Dr. P. then explained the system he advocated for this purpose: That a few medical men should be selected for the various districts, to be paid a small sum, to furnish the Department with periodical statistics. To do this in the whole country would take a very large sum of money. He therefore advocated beginning with the towns and cities.

Dr. Hingston (being absent) had sent a letter giving his views. He thought that the scheme advocated by Dr. Playter would not produce any result. He would prefer advising the insistance upon correct mortuary returns throughout the country and the adoption of a uniform table of diseases in all parts of the Dominion.

Dr. Grant said that no one must suppose that the Government had any intention of giving the cold shoulder to the agricultural districts; on the contrary, the towns were alluded to simply because they were each the centre for an agricultural district.

Dr. McDonald thought that neither the Government nor the country were ready for such a report. Any scheme of this kind should receive very careful thought, and he was of opinion that we were not yet ready with a well-prepared reply to the request of last year; and considered, therefore, that it would be better to delay action for another year.

Dr. Sloane would also vote for postponement.

The amendment was then put and lost upon a division, and the resolutions as recommended by the committee were adopted.

The Nominating Committee then handed in the following report:—

President—Dr. Mullin, Hamilton.

Vice-Presidents—For Ontario, Dr. Tye, Chatham; for Que-

bec, Dr. Gibson, Cowansville; for New Brunswick, Dr. Atherton, Fredericton; for Nova Scotia, Dr. Jennings, Halifax; for Manitoba, Dr. Kerr, Winnipeg.

General Secretary—Dr. Osler, Montreal.

Treasurer—Dr. Robillard, Montreal.

Local Secretaries—For Ontario, Dr. Saunders, Kingston; for Quebec, Dr. Brunelle, Montreal; for New Brunswick, Dr. Coleman, St. John; for Nova Scotia, Dr. Almon, Jr., Halifax; for Manitoba, Dr. Whiteford, Winnipeg.

Committees—On Publication, Dr. Geo. Ross, Montreal; Dr. J. H. Cameron and Dr. Fuller, Toronto; the General Secretary and the Treasurer. On Therapeutics, Dr. H. Punget, chairman. On Medicine, Dr. Stewart, Brucefield, chairman. On Surgery, Dr. Grassett, Toronto; Dr. Brunelle, Montreal. On Obstetrics, Dr. Kennedy, Montreal, chairman. On Necrology, Dr. Fulton, Toronto; Dr. Atherton, New Brunswick; Dr. Lachapelle, Montreal. On Climatology, Drs. Larocque, Montreal; Botsford, St. John; Worthington, Clinton; and Playter, Toronto. On Ethics, Drs. Malloch, Hamilton; Gardner, Montreal; Chas. Morrison, London. On Arrangements, Drs. Sullivan, Saunders, Fenwick, Metcalf, and Sweetland.

The Committee recommended Kingston for the next place of meeting.

Dr. McDonald moved the report be adopted.

Dr. Roddick moved in amendment, seconded by Dr. A. H. Wright, that the next place of meeting be Montreal.

After some discussion, a division was taken, when it was decided by a considerable majority to go to Kingston next year.

Votes of thanks were then given to the Mayor and Corporation of the city of Toronto for the use of their City Hall; to the profession of Toronto for the cordial reception and abundant hospitality accorded to the Association; and to the various Railways and Steamboat lines which had kindly given greatly reduced fares to members.

Moved by Dr. H. P. Wright, seconded by Dr. Ferguson, that the travelling expenses of the Secretary and Treasurer be paid. *Carried.*

Moved by Dr. Canniff, seconded by Dr. A. H. Wright, that a copy of the Special Supplementary Report be sent by the Secretary to the Premier, Sir John A. Macdonald. *Carried.*

The President then left the chair, which was taken by the President elect, Dr. Mullin, and a cordial vote of thanks was given to Dr. G. E. Fenwick for his able conduct and courteous demeanour in the chair throughout the meeting.

The assembly then dispersed, agreed that the meeting had proved entirely successful.

On the evening of Thursday, the profession of Toronto entertained the Association at a conversazione, held in the fine rooms of the Educational Department. Dr. Canniff, Chairman of the Committee of Arrangements, presided, and did the honors with his well-known ability and courtesy. Dr. W. B. Carpenter was present and gave a short address, which was listened to with great attention. Besides instrumental music, a choice selection of songs and ballads was furnished by a number of amateurs, amongst whom were several members of the fraternity in Toronto. There was a very large gathering of the citizens, and a most enjoyable evening was spent.

On Friday, Dr. Daniel Clarke, Superintendent of the Lunatic Asylum, invited all members of the Association who could remain, to lunch at the Asylum. A considerable number of members availed themselves of the invitation, and were handsomely entertained by Dr. Clarke, and also visited the admirably conducted institution over which he presides.

The Toronto General Hospital was thoroughly inspected by many of the visitors, who were always cordially received by Dr. Chas. O'Reilly, the medical superintendent. A number of improved novelties were shown in this excellent establishment, and we were glad to find that they are in a position to very shortly erect a Convalescent Hospital within their own grounds. A most useful adjunct is an ambulance constructed upon the most approved plan.

American Association for the Advancement of Science.—The annual meeting of this Association, held in Montreal last month, proved highly successful. The proceedings of the sectional meetings have been very fully reported in the daily press. Many subjects bearing upon medical science were discussed. We had hoped to give some account of these in the present number, but owing to the space occupied by the full report of the Canada Medical Association meeting, are obliged to hold this over till our next issue.

Semi-Centennial Celebration of the Medical Faculty of McGill University.—The Dean and Medical Faculty have issued invitations to all their graduates and to a large number of friends of the University, for a conversazione on the 4th and a dinner on the 5th October. The former will be held at the new Peter Redpath Museum, and the latter at the Windsor Hotel. The celebration is intended to mark the opening of the 50th session of the Faculty. The occasion is a worthy one, and we hope to see the graduates collected in great numbers from all parts of the country to do honour to their *Alma Mater* on the day of her golden wedding.

Medical Items.

Provincial Medical Board.—The semi-annual meeting of the Board of Governors (Provincial Medical Board) of the College of Physicians and Surgeons of the Province of Quebec, will be held on Wednesday, the 27th September, at 10 A.M., in the Laval University, Quebec. Candidates for examination or for license must send their papers (including certificate of admission to the study of medicine), also the fee for the license, $20, at least ten days previous to the meeting, to either of the secretaries.

Personals.—Dr. Henry Jackson has been elected Professor of the Institutes of Medicine in the Vermont Medical College, Burlington.—Angus M. Cattenach, of Dalhousie Mills, Ont., M.D. (McGill, '82), has passed the L.R.C.P., Edin.—Harry A. Eberle, M.D. (McGill, '76), has moved from Webster City, Iowa, to Kansas City, Mo.—M. C. Rutherford, M.D. (McGill, '79), has moved from Kenyon, Minn , to Fergus Falls, in the same State.—J. W. Ross, M.D. (McGill, '81), is at Cohoes, N.Y., not Lansenburg, N.Y., as stated in the McGill announcement.—T. A. Jamieson, M.D. (McGill, '75), is at Fort Covington, N.Y.—Duncan McGregor, M.D. (McGill, '61), has moved from Chatsworth, Ont., to Winnipeg.

CANADA

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Original Communications.

CANCER OF THE BREAST IN ITS RELATION TO PAGET'S DISEASE OF THE BREAST.

By J. A. GRANT, M.D., M.R.C.S., Ottawa.

(*Read before the Canada Medical Association, at Toronto, September*, 1882.)

Mrs. M. C., aged 39 years, mother of three living, healthy children, the youngest of whom is aged 1 year and 5 months, of short stature and regular conformation, rather pale complexion, and temperate habits, was admitted by Dr. St. Jean into the Ottawa General Hospital, August 5th, 1882, owing to the existence of a tumour in the right breast, of considerable size and hardness, and having a nodulated and irregular feel; glands in the axilla and same side of the neck implicated, and possessing considerable hardness. On the surface of the breast, towards the subclavicular region, several small and well-defined superficial nodular growths exist, having a slightly discoloured condition of the skin, hard and sensitive to moderate pressure. Family history good, and menstruation always regular. The first trouble experienced in the breast was an eczematous eruption covering the greater part of the areola, to which little attention was paid until after a lapse of several months, the exact period not being known. A sense of uneasiness in the gland, associated with a hardness about the parts, then, for the first time, attracted particular attention, having to earn a living, in a rough country district, by vigorous manual labour. At this stage, operative interference was decidedly objectionable.

The fact of chronic eczema of the nipple being closely connected with mammary cancer was first observed by Sir Jas. Paget in 1874. In the London *Lancet* of January 27th, 1877, he most cautiously expressed the opinion that he could only speak of the clinical character of these cases. He had no doubt of the frequency with which chronic eczema, or any chronic irritative disease of the breast or nipple, was followed by cancer. Fifteen or twenty cases had come under his observation, from which he was led to believe "that if any irritative condition were present in the skin of the areola and nipple for a period of three or four years (the patient being of an age favourable to cancer), cancer of the breast would ensue." The clinical value of this fact was so important that in December, 1879, at a meeting of the Royal Medico-Chirurgical Society, Mr. Erichsen stated "he could not but think that this condition of nipple, when associated with cancer, was something different from any known form of cutaneous disease," and attention being first called to it by Sir Jas. Paget, he termed it "Paget's Disease of the Nipple." At a meeting of the Royal Medico-Chirurgical Society, January 23, 1877, Dr. Thin maintained that the supervention of cancer upon eczema of the nipple was unknown, except in London. It is true that, as far as Ottawa is concerned, during a period of 28 years work in two General Hospitals, the present is the first opportunity which has presented of recording this peculiarly interesting clinical fact.

Dr. Thin, in examining carefully the histology of this disease, has come to the conclusion that the breast-tumour in Paget's Disease is actually duct cancer, developed from the epithelium of the lactiferous ducts, and never true scirrhus or parenchymatous cancer, which he considers is developed from the secreting epithelium of the acini: so, from the origin of the disease, which spreads downwards to the gland and promotes at the same time, superficially, this type of eczema, termed *papillary dermatitis*. In examining into the clinical history of this subject, we find that Walshe, "on the Nature of Cancer, 1846, p. 473," has recorded, in reference to cancer of the breast, that the skin sometimes undergoes cancerous infiltration coevally with, and,

as it were, independently of, the subjacent structure," or the disease actually commences in the cutaneous surface. Thus we observe that the attention of pathologists has long been directed to the cutaneous importance of cancerous disease, a few histologists like Mr. Butlin holding that all varieties of cancer have an epithelial origin. Gross (Vol. II, p. 272) writes: "Although scirrhus generally commences in the glandular structure of the mamma, yet occasionally its primitive seat is in the common integuments, &c."; thus we observe here a recognized principle. The great majority of pathological productions contain cells analogous to epithelial cells, or to the corpuscles of the connective tissue. (Virchow's Cellular Pathology, p. 63.) That we may have eczema of the breast, independent of cancer, is undoubted; hence the importance of discriminating between the purely simple and the *malignant papillary dermatitis*. The age of the individual, the duration of the disease, the intractable character, associated with the well defined margin of malignant dermatitis, and the evidence, when the tissue is grasped between the fingers, of infiltration in the papillary layer, doubtless point to the true character of the diseased condition. The demonstration within the past few years, of a local cause of several cutaneous diseases, formerly classed as expressions of blood states, is undoubtedly an advance beyond the old basis of an undefined *materies morbi*. Still, error would arise out of a general acceptance of such local power. From the microscopic character of eczema, Dr. Bulkley is disposed to consider it more decidedly constitutional than local. (Virchow's Cellular Pathology, p. 61.) "In the micrographical school of the west, a certain number of observers have come to the conclusion that in the series of new formations there is only one particular structure which is specifically different from natural formations—namely, *cancer*." Under such circumstances, traced up diversity becomes doubly interesting. The nature of eczema, as described by Dr. Tilbury Fox in London *Lancet*, in 1870, is not supposed to arise from mere capillary excitement; that capillary congestion is a sequence of cell activity, and that the abnormal state of the cells may be the result of perverted

nutrition, as defined by Hebra. Dr. Bulkley of New York (Report on Eczema and Psoriasis, International Med. Congress, Phl.,) expresses his opinion "that there is no proof that this cell change is really primary in eczema, and independent of constitutional conditions, and that it exists as a local affair." From such deductions, the physiological importance of the skin, in its relation to subjacent parts, cannot be over-estimated. At every stage of life, in rugged health as well as in diseased conditions, we trace the outcome of nature's efforts on the cutaneous surface. Thus the apparently healthy skin of markedly eczematous subjects becomes, both before and after local disease, an interesting field of observation. The most important point, however, is the part the diseased tissues take in eczema, as to primary or secondary significance. Thus far the question is in doubt. It is an interesting analogy to observe how, on the one hand, lingual and buccal psoriasis become transformed into true epithelioma, and, on the other, eczema of the nipple into cancer of the breast. Here, again, we trace analagous pathological bearings between surface and interior. In the unsettled state of the subject, the question of treatment becomes difficult. Practical experience, the outcome of patient and careful observation, will, fortunately, as a general rule, guide and direct the most prudent action under such rare circumstances.

A CASE OF TUMOUR OF THE BONES OF THE SKULL PRESSING ON THE BRAIN.

By Dr. PREVOST, Ottawa, Ont.

(Read before the Canada Medical Association, at Toronto, September, 1882.)

On the 12th of May, 1882, M. C., aged 58 years, raftsman, came to consult me with regard to a tumour situated in the forehead. The patient, to all appearance, was a strong, robust man, complaining only of this growth that he wished to rid himself of. I could discover no hereditary taint of any kind; he never had syphilis, and always enjoyed perfect health, notwithstanding the twenty years hardship of a shantyman's life. However, within the last seven or eight years, every autumn, he has been subject to neuralgic pains in the course of the right trifacial

nerve. His sufferings, although very acute, were always of short duration, never preventing him attending his work. During the fall of 1881 this neuralgia did not reappear. Towards the end of January, 1882, passing, by chance, his hand over his forehead, he discovered a small opening in the frontal bone, covered by the skin. This he at once communicated to his friends. They found there really was a hole in the bone, and, moreover, a slight tumefaction, a lump on the side of this little opening which had then the size of a 25 cent piece. The patient feeling in perfect health, and experiencing no pain whatever, this discovery caused him no anxiety. Nevertheless, the lump augmented gradually, until at last it bulged under the skin. At the beginning of the spring the patient, becoming anxious about the development of the tumour, came to Pembroke, where he consulted several physicians. One of them plunged an exploratory needle into the lump and withdrew pure blood. They told him to return home and avoid falling or any kind of hard work, that he was affected with an aneurism, and no surgical intervention was possible. He then came to me.

To the right of the median line of the forehead there projects a lump about the size of a large orange, almost regularly spherical, except on the external side, where it seems to be elongated, decreasing in bulk. There is no discoloration of the skin, which is moveable over the tumour. The latter is elastic, moderately tense, boggy, offering to the hand the sensation of a false fluctuation. It pulsates synchronously with the heart's action. This character, although very slight, is perfectly distinct. Respiration has no effect whatever upon the tumour. By a steady and continued pressure of the hand the tumour is almost obliterated, and we perceive that a large portion of the frontal bone has disappeared, leaving an aperture of two or three inches in diameter. Through the skin the edges of this perforation appear to be serrated, irregular, and tender to the touch. The compression of the tumour and the reduction of the latter caused no feeling of uneasiness to the patient, neither any appreciable physiological phenomena. This growth, according to the patient's own observation, does not always present the same volume, but

ordinarily bulges more in the afternoon, decreases in the morning and during the forenoon. Within the last few weeks, he complains also of weakness of vision in the right eye. The general health is good. The heart and lungs present nothing abnormal, and the digestive functions are properly performed. There is absolutely no trouble of motility or sensibility.

Owing to the situation and character of the tumour, my attention was attracted towards the intellectual functions, and I looked for some signs of cerebral compression, but, strange to say, there, also, the symptoms remained almost entirely negative. There was, it is true, a certain appearance of dullness and stupidity in his face, but, for all I knew, that state might have been innate and habitual. Although he supplied the elements of the present observation, I must confess that it was hard work to me to gather the facts, owing to the lack of lucidity of his mind and the slowness of his answers. Quietly sitting in his chair, he seemed silent and drowsy. I asked him to accompany me to the medical meeting taking place that evening; he readily consented. It was growing late. I said to him: "We must hurry; being a shanty-man, you must be a good walker; can you follow me?" He replied in the affirmative, and I started ahead. But I soon noticed that he was astray in his calculations concerning his capacities, for I had to wait for him two or three times. I even had to return to meet him, and found him walking slowly, head bent, and looking distracted. On speaking to him, he, each time, suddenly quickened his step, as if he had forgotten that he was coming with me, and would soon fall back into his old gait. The assembled physicians examined him. His answers were laconic, but clear, and with no disturbance of speech. On leaving the meeting, I asked him if he could reach his boarding-house alone; he said "yes," and I left him. But the next day I learned that he had lost his way, with which he was, however, familiar, and had not come in until five o'clock in the morning. Two days after he entered the hospital, and soon fell into a state of total indifference, passing his time in bed, not asking for food or anything whatever. I then noticed a well-marked degree of exophthalmos of the right eye, the volume of which kept the

lids apart. The eye-ball also appeared to be somewhat softened. The skin covering the tumour presented a reddish colouration, and was traversed with dilated veins. On the 16th of May, at noon, I found him in a state of coma, the pulse beating 140, with high respiration. In this state he remained until death, which ensued at six o'clock in the evening.

At the autopsy, made eighteen hours after death, I found the tumour partly sunk in. The skin covering it had resumed the colour of the skin of the rest of the face, and was furrowed with wrinkles. I dissected two flaps that I drew back to expose the tumour, which appeared bulging through the perforation of the bone, and presenting a smooth aspect and a bluish hue. Incised in its horizontal diameter, it appeared composed, in the most external portion, of a soft, reddish-brown tissue, extremely vascular, and contained in a very thin web. Gradually, and especially under the level of the frontal bone, the consistency changed and presented the aspect of a greyish pulp, similar to the cerebral substance, although a little softer, which I scooped out with a spoon. This substance filled a cavity of the size of a hen's egg, situated between the bone and the dura mater. This latter membrane was depressed backwards, driving before it the right cerebral hemisphere, which it compressed almost on a level with the temporal bone. The dura mater was perfectly sound, without any vascular injection, and, after the evacuation of the cavity, it kept up the rounded depressed form impressed upon it by the neoplasm. The posterior part of the orbit appeared also to have been invaded by the morbid growth, which accounts for the exophthalmos noticed during life.

This patient, gentlemen, was affected with an encephaloid medullary cancer of the frontal bone, and the vascularity of its texture ranges it in the class of these morbid products to which Hey has given the name of *fungus hæmatodes*. This disease has long been, and is still by some writers, designated exclusively under the improper term of fungus of the dura mater. In fact, Louis, and all the surgeons preceding him, claimed that all the cancerous tumours of the vault of the skull constantly originated on the external face of the dura mater, and then proceeded to

wards the integument, after having perforated the cranial box. In 1785, Sandiford and Siebold were the first to renounce these exclusive theories demonstrating that these tumours originated in the diploë. A few years afterwards, Lassus, in his Treatise of Surgical Pathology, and Waltier and Chelius, proved by indisputable observations the multiple origin of the cancerous growths of the skull ; and to-day almost all surgeons admit that these tumours may have their origin in the integuments, the bones, the dura mater, and even in the brain itself.

In the case which I have the honour to submit for your consideration, it is evident that the morbid process originated anywhere else than in the dura mater, which, at the autopsy, appeared free from all alterations, presenting all the characters of the normal membrane. The clinical history of the case demonstrates, besides, that the bone must have been the primary seat of the growth, which, after having perforated the frontal, bulged beneath the integuments on the one hand, and pressed back the dura mater on the other, and also the cerebral hemisphere. Cancer of the bones of the skull ordinarily shows itself in adults, and appears sometimes solitary, and at others as a manifestation of generalized cancerous diathesis. The morbid product begins sometimes between the bone and the periosteum, and then develops itself externally by propagation to the integuments. But, generally, the process begins within the diploë, separates the internal table from the external, which, being absorbed, disappear, producing a perforation of a more or less extensive size, with rough, bristling, serrated edges, indicating a rarifying osteitis, ending in partial necrosis. The symptoms vary according as the tumour begins on the external surface of the bone or within the diploë. In the first case, we may feel a more or less soft lump, giving the sensation of false fluctuation, and liable to present the character of a real liquid tumour. When it originates within the diploë, it might remain a long time without showing any external manifestation ; but, little by little, the external table gets thinner and thinner, owing to absorption, and the growth allows itself to be depressed by the finger, which experiences the sensation of a parchment-like

crepitation. When the bone is entirely perforated, the fungus raises the skin and appears as a rounded, elastic tumour, beating synchronously with the pulse, and more rarely with the movements of respiration. If the internal table has been absorbed, the tumour is totally or partially reducible, and the osseous perforation can then be felt. Sometimes this reduction of the tumour induces cerebral disturbances, such as syncope, convulsions, epileptic seizure; at other times it takes place without any accidents, as in the present case. These cerebral symptoms often appear spontaneously, and, consequent upon the progress of the disease, the patient experiences then numbness of the limbs, syncopes, paralysis, coma—in short, all the signs of cerebral compression. Death, then, is not far off. Sometimes the tumour ulcerates, and the patient dies from hemorrhage or exhaustion. The duration of the disease may be pretty long, but, when once the bone is perforated, it is seldom prolonged beyond one or two years. Death might occur a great deal sooner, as is shown by the present case, which went through all its stages in five months.

As you may have noticed, at the reading of this observation, the tumour was the occasion of an error of diagnosis, and was mistaken for an aneurism. Instances are not uncommon in the records of science, where a similar mistake has been committed, and the diagnosis of encephaloid of the bones of the skull is certainly surrounded with certain difficulties, which, however, are not insurmountable, as can be demonstrated by the following considerations:

The reducibility by pressure, the pulsations synchronous with the beatings of the pulse, allowed us at once, in this case, to range the tumour in the class of tumours communicating with the cranial cavity, and to eliminate from the diagnosis all the morbid growths situated at the surface of the vault of the skull. Amongst the former, encephalocele, aneurisms of the middle meningeal artery, and fungus of the dura mater, were the only ones which might have induced a mistake. But encephalocele is a congenital disease, or produced by a blow, a fall, with fracture of the skull, besides having its seat generally at the

posterior part of the head. Nothing in the history of the case showed that any of these different characters were present.

Aneurism of the middle meningeal artery has, on the skull, a seat different from the one occupied by the fungus in this case. It shows itself naturally in the course of the artery, that is, on the lateral parts of the head. The pulsations, in aneurism, are besides a great deal more energetic than those noticed in the cancers of the bones, whatever may be the vascularity of the latter. Under the influence of pressure, the aneurism is reducible, it is true, but as soon as pressure is removed the tumour resumes its primitive volume almost suddenly, after two or three cardiac pulsations, whereas, in encephaloid, it is not until after a larger number of these pulsations, and slowly, that the neoplasm comes back to its primitive form. Blowing is absent in the fungus, and the compression of the carotid, which suppresses the pulsations in aneurism, has no influence upon the beatings with which the fungus is agitated. As far as the differential signs are concerned between encephaloid of the bones of the skull and fungus of the dura-mater, I must confess that they are very often wanting, especially at the last period of the disease. Perhaps, in the fungus of the dura-mater the cerebral symptoms are of a more frequent occurrence, as well as certain functional symptoms, such as neuralgias, deafness, and so on; the error, however, would be of little importance, the prognosis being similar in both cases, and also the indications of treatment, which are total abstention of all surgical interference. In fact, the nature of the morbid product and its situation amply suffice to restrain the hand of the surgeon. Nevertheless, it has been advised to largely lay bare the fungus, circumscribing it by a sufficient number of crowns of trephine, and to make a complete extirpation of the growth. Grossman, Peccholi and Nelaton seem to have obtained real success by this means. But these cases are not numerous enough to justify the surgeon in resorting to such a grave operation, especially when one has to deal with a disease the nature of which is, sooner or later, certain of reproduction. Upon the whole, every time we have to deal with a tumour, dense, elastic, semi-fluctuant, situated on the

vault of the skull, especially in the frontal region, beating synchonously with the heart's action or with the movements of respiration, reducible under pressure, through a perforation of the skull, slowly resuming afterwards its former state, being neither the seat of blowing nor influenced by the compression of the large vessels, let this tumour be accompanied or not with symptoms of cerebral compression, we may, without fear, pronounce it to be a cancerous tumour having originated either on the surface of the dura-mater, or, rather, within the diploë of the skull—an affection certainly fatal, and giving rise but to indications of a mere palliative treatment.

Gentlemen, I thought this observation interesting, for several reasons, but among the facts that I cited there is one which, in my humble opinion, surpasses all the others. It is the considerable degree of compression which the morbid growth produced upon the brain, at the same time with an almost total absence of the physiological phenomena that we had reason to expect. This fact, although not uncommon, is none the less remarkable, owing to the group of symptoms which classical authors generally attribute to the compression of the encephalon. This relative integrity of the cerebral functions, noticed in our patient, may seem extraordinary at first sight; however, we find a satisfactory explanation in the recent ideas of science, by means of numerous and judicious observations. We can comprehend the physiological phenomena due to cerebral compression, either by an attrition of the elements of the substance of the brain, either by the changing of the parts constituting it, or by the impaired circulation resulting from the external pressure. The absence of one or more of these elements suffices to present the exterior manifestations liable to be determined by the compression. Without going so far as Gama, Desault and Malgaigne, who almost completely annuled the influence of compression, attributing the disturbances to an inflammation of the brain or its membranes, it is nevertheless true that the functional disorder is subject to many circumstances, such as the situation, the extent and the nature of the compressing agent, as well as the more or less rapidity of its formation. For instance,

compression of the base of the skull is almost always followed by appreciable symptoms, whereas a similar lesion at the convexity of the hemisphere is often devoid of any. This fact is in conformity with the ideas given by experimentation, which teaches that the periphery of the brain is insensible to physical and chemical irritants, whilst the irritation of the protuberance, the peduncles and the bulb give rise to troubles of motility and sensibility. The nature of the compressing element plays also an important part in the more or less frequency of the physiological disturbances, and these latter, which are rarely wanting in abscess of the brain, are due to the inflammation of the parts in contact with the pus rather than to the compression produced by the purulent collection. So much so, that examples are very rare in science where the evacuations of a cerebral abscess has produced the cessation of the symptoms, which, on the contrary, persisted with almost the same intensity. Lastly, a sudden compression would more surely produce cerebral symptoms than that due to a lesion gradually developing itself, and permitting, as it were, the brain to become accustomed to the presence of this foreign body. In this case the tumour was situated on a level with the convexity of the hemispheres, though subjacent parts were the seat of no organic alterations, the growth gradually increased, so we must not wonder if the signs ordinarily attributed to compression of the encephalon were almost completely wanting.

CASE OF ECHINOCOCCUS DISEASE OF THE LUNG.

By DR. BLACK, Uxbridge, Ont.

(*Read before the Canada Medical Association, at Toronto, September*, 1882.)

I was consulted in the latter part of November, 1878, by Mr. R., Primitive Methodist minister, native of Essex, England, and a resident of Canada for about six years, whose health had been gradually failing for about four years. In 1876 he had been under the treatment of Dr. Aikins, of Toronto, who had punctured and removed the contents of a hydatid tumour of the liver; after which, for a time, the patient's health had improved,

but the improvement was not lasting. During a year and a half previous to consulting me, he had steadily been becoming less fit for attending to the duties of his profession.

The patient was very much emaciated ; sallow complexion, nostrils dilated ; countenance had a pinched and somewhat cachectic appearance, appetite had largely failed, a good deal of gas in the abdomen, bowels constipated, and there was some dyspnœa, with a dry cough, particularly when in the recumbent position. The epigastrium and right hypochondrium were tense, and somewhat painful when subjected to pressure ; the lower intercostal spaces on the right side were enlarged and tense ; the upper part of the right lung was in its normal condition, as was also the whole of the left lung. There was, however, very marked dullness over the lower part of the right lung, the highest point of dullness being in the region of the nipple, in the axilla, and close to the sternum ; at the vertebral column the points of dullness were about an inch lower. The heart's position and sounds were normal, though it was greatly deficient in force. The spleen was very little in excess of its natural condition. The right lobe of the liver was large, hard and smooth, particularly along the lower margin of the dull space ; and the diaphragm, on the right side, had little or no action. From these signs I inferred that a tumour of some kind, situated in or on the upper part of the liver, was projecting into the thorax. Had the pain been more acute and persistent, the cachectic appearance of the patient, combined with the fact that the tumour did not present any traceable fluctuation, would certainly not have led me to the diagnosis of *echinococcus*. The fact, however, that the patient had been afflicted with that disease two years before, coupled with the long duration of the tumour and the absence of acute pain, induced me to favour the opinion that the existing trouble was an offshoot from the former, or, perhaps, more correctly, a continuation of it.

My faith that the results of treatment would prove in any degree satisfactory not being of the character that was calculated to remove mountains, I advised that the opinion of some one possessed of more skill and experience in the management of

such cases should be sought, and suggested that the gentleman, Dr. Aikins, who had had charge of the case in 1876 should be consulted. My advice was followed, and the patient brought back a very unfavourable prognosis. So far as treatment was concerned, there was not the smallest suggestion thrown out. I inferred that the doctor did not look upon treatment as being of any service, further than the treatment of symptoms for the relief of the patient, as they occurred. Fl. Ext. Rhei and Taraxaci were prescribed to counteract the constipation, and a cinchona bark tonic, with a little Spt. Amm. Arom., for the purpose of helping to raise the gas from the stomach.

Dec. 10th.—Little or no change in the condition of the patient.

Dec. 24th.—Acute persistent pain in the upper hepatic region, with repeated rigors, followed by heat and perspiration; obstinate constipation of the bowels; pulse 125; temperature 103½°. Calomel, opium and quinine, with counter irritation, followed by warm cataplasms over the seat of pain, were prescribed.

From this time until the beginning of January the patient had repeated attacks of rigors, and the pain, though not so acute as on the 24th, was very severe, the pulse varying between 105 and 120, and the temperature between 100° and 103°. Specific gravity of urine, which was scant and high-coloured, was 1010. It gave considerable bile-pigment reaction.

Jan. 4th.—No rigors; great tenderness over the liver; the dullness in the lung has pushed its way up in the axilla and close to the spine about an inch and a half further than it was previous to the attack of December 24th; spleen increasing in size rapidly; dyspnœa more marked; some œdema of the feet; and great unrest, the patient not being able to assume any other than the sitting posture. The same medicines were again prescribed that were used before the attack of the 24th ult., sulphuric ether taking the place of the spt. amm. arom. Urine 1008.

Jan. 27th.—Up to this time there has been no change, except increased emaciation, with general aggravation of all the features of the case. I now fancy I detect some slight tubercular indications in the upper part of the right lung. On enquiry I find that several of his relations have died of phthisis. I add stimulants to the other treatment.

Feb. 10*th.*—Patient very much exhausted; dyspnœa and cough greatly increased, the rapid growth of the spleen interfering with the action of the left lung. The dullness in the upper part of the right lung is much increased, and the patient has hectic fever, with exhaustive night sweats. The impulses of the heart indicate its position to be nearly on a level with the left nipple. The lower limbs are very much swollen. Pulse 110; temperature 101°.

From this time during two weeks there is no new feature in the case.

Feb. 25*th.*—After a coughing fit of a most distressing character, the patient raised nearly two pints of purulent fluid, in which floated a large number of small cysts, the largest of which, in their collapsed condition, would, in their longest diameter, measure two or three inches, while the smallest specimens were barely perceptible. This was followed by complete prostration, from which, under the influence of stimulants, the patient rallied towards night.

Feb. 26*th.*—Patient had secured more sleep than had fallen to his lot in one night since the 24th December. Dyspnœa was not so great as it had been for some time, and the patient was actually cheerful, and entertaining hopes of recovery. The heart impulses were not so much to the left as they had been previous to the discharge through the bronchi on the 25th.

From this time until the day of his death the patient continued hopeful of recovery. Appetite was better, bowels more regular, and breathing less difficult. With the exception of the œdema of the lower extremities, the symptoms were all less distressing. He daily raised less or more purulent matter and some cysts.

March 10*th.*—He had succeeded in raising a cyst of larger dimensions than any of its predecessors, and was exhibiting it and saying, "Here is a fine fellow I must keep for the doctor," when, giving a sudden cough, purulent matter began to boil out of his mouth and nostrils, and he was strangled instantly.

Autopsy 16 *hours after death.*—Did not examine the cranium. In the thoracic cavity found indications of the existence of an

abscess in the lower part of the right lung, which had been distinct from that of the liver. The purulent matter and cysts discharged on Feb. 25th, and from that time until the 1[th of March, I believe to have been the contents of this abscess. The cavity was flooded by a greenish-yellow purulent fluid, and floating cysts discharged from the hepatic abscess. The heart was lying with its apex directed to the left, nearly beneath the left sterno-clavicular articulation. The upper part of the right lung was studded with tubercle. The left lung was in its normal condition. The diaphragm was pushed far up into the thorax; the liver was adhering to the diaphragm, and through the diaphragm was a large opening, which communicated with an immense cavity in the liver. The rupture of the diaphragm, and the consequent discharge of the contents of the hepatic abscess, I believe to have been the immediate cause of death. The cavity in the liver was about 9½ inches in depth and 6 inches across; in the cavity was still a large quantity of greenish-yellow fluid like that found in the chest. The liver was of immense size, and studded with tubercle of a yellowish colour, many of which were about the size of a pea. The spleen, which we have here, had imbedded in it this large cyst, filled with a clear fluid, in which I could detect no scolex. The intestines were anæmic; kidneys normal; bladder normal and empty.

ABSTRACT OF PAPER ON OPERATION FOR CLOSURE OF THE HARD PALATE AND HARE-LIP IMMEDIATELY AFTER BIRTH.

By D. H. GOODWILLIE, M.D., New York City.

(*Read before the Canada Medical Association, at Toronto, September*, 1882.)

In many cases there is tissue enough developed, but there is a failure to unite, and the maxillary bones are separated, making the diameter from side to side greater in proportion to other parts of the face. What is of special importance in this method is to restore the bones to the normal position without any loss of hard or soft tissue, except so much as would be required to freshen the edges of opposing parts. The cleft of the hard palate and lip, if any exist, should be done soon after birth, and

before the child is two months old, to avoid injuring the developing teeth. The closure of the soft palate, if it is to be by a surgical operation, should be done, if possible, before the child begins to speak, at about 2 or 3 years of age.

My method I will illustrate by a case represented in the wax model that I pass around, and which was taken from a cast of a child one week old, and also by diagrams. By its examination you will see presented a cleft of the lip on the left side, and also a cleft through the left of the intermaxillary, extending through hard and soft palate. Bone development has been sufficient in amount, but there being a failure to unite the two sides in the process of growth, the bones became separated, and the intermaxillary attached to the right maxillary leaves the normal anatomical form of the anterior alveolus and becomes more or less straight, the end of the intermaxillary protrudes forward into the cleft of the lip. By this straightening process the nose is carried to the right side, as the anterior part of the nasal septum rests on the intermaxillary, while the left ala is very much stretched to the left. The usual practice is to only close the lip in infancy ; but in order to do so it is necessary to have the protruding end of the intermaxillary removed either by cutting it away or crushing it, both of which means is bad surgery. In the former, the bone is removed with all the teeth germs ; and in the latter, the germs are destroyed and the parts misshapen. And also to dissect the lips from the bone to allow them to approximate.

The operation for the relief of the deformity the model represents in this case was made in the following manner: The child was placed under an anæsthetic, and by means of a small revolving knife and the surgical engine a small V-shaped section was removed inside of the alveolar process of the intermaxillary, also running up into the septum a very little, and at the same time the edges of cleft of the hard palate were freshened by the revolving knife. Holes were also cut on either side of the hard palate for the purpose of passing suture pin clamps to hold the maxillæ together. Just enough was taken away by the V-shaped section to allow the alveolus of the intermaxillary to resume its

normal position. Now, by means of a properly-constructed forceps the maxillary bones were forced together so as to close the cleft in the hard palate. Then a nasal forcep was passed into the nostrils, grasping the septum, and the nose drawn into perpendicular position, and, at the same time, the intermaxillary was forced into its normal place, closing up the V-shape section made by the revolving knife. The alveolar ridge of the intermaxillary now connects with the maxillary of the opposite side. They are now held together by the suture pin clamps which I have devised for the purpose, and made of the very best steel and gold plated. The cleft in the lip is now closed by first carefully applying the compression lip clamp on each side of the cleft lip to prevent hemorrhage. After the edges are pared, then carefully approximate both skin and mucous membrane by passing the first suture in the vestibule of the nostril and ending with the vermilion border, and then complete the operation by passing the suture pin clamps to take the stress off the sutures.

In all simple or double clefts, all bone tissue should be preserved to prevent deformity in adult life.

The advantages of this method are: 1st, The cleft in the hard palate is closed in all cases where there is the normal amount of bone developed. 2nd, The alveolar ridge with the tooth germs are saved and brought into place, securing, as near as possible, the normal outline of the mouth and subsequent development of the teeth. 3rd, The nose is brought into normal position and over-distended nostril restored. 4th, The external normal appearance of the face is reclaimed.

BI-MONTHLY RETROSPECT OF OBSTETRICS AND GYNÆCOLOGY.

Prepared by WM. GARDNER, M.D.,

Prof. Medical Jurisprudence and Hygiene, McGill University; Attending Physician to the University Dispensary for Diseases of Women; Physician to the Out-Patient Department, Montreal General Hospital.

A New Method of Rendering Sponge Tents Aseptic.—Since the introduction of laminaria and tupelo tents and the method of rapid dilatation, sponge tents have been used much less fre-

quently than formerly. The profession gladly welcomed any means of dilating the uterus unattended with the putrefaction and its attendant dangers which so frequently follows the use of sponge. Experience, however, has shown that for certain purposes we possess in sponge, used as a dilator, a therapeutical agent which cannot be replaced by any of the other methods of dilatation. Such conditions are chronic inflammation of the uterus, body or cervix, and the soft, flabby condition of subinvolution. In such conditions the hyperæmia, softening and serous infiltration of the uterine tissues induced by the dilating sponge-tent, are followed by a stimulation of the absorption process to such an extent as greatly to reduce the size of the organ. No method hitherto employed to render sponge aseptic, such as by the use of carbolic acid, has succeeded in preventing the frightful stink of the sponge-tent when removed. This, however, was attained to some extent by Dr. Albert Smith of Philadelphia, by greasing slightly the sponge-tent and then coating it with finely-powered salicylic acid. This experience of Dr. Smith suggested a similar employment of iodoform to Dr. Ernest Frænkel, private docent at Breslau. He took the ordinary cerated sponge-tents, rubbed them well with salicylated cotton, and then coated them from base to apex by rolling them in iodoform. He then filled the vagina with tampons of iodoform-gauze made by Kahnemann and Krause of Vienna. When the tents were removed 18 or 20 hours later, there was absolutely no offensive odour, and particles of the iodoform were still to be seen in the cervical canal and adhering to the sponge tents. The method can be used just as well with laminaria and tupelo tents as sponge and preliminary anointing of the tents with carbolated or borated vaseline will probably be better than with simple cerate. I can testify from recent personal experience how completely free from putrefactive odour a sponge-tent thus treated is, when removed from the cervix, where it has lain for 24 hours. In a recent case, with a view of rendering asepticism more certain, I passed a few grains of iodoform into the uterine cavity before inserting the tent.—(*Centralblatt fur Gynäkologie*, No. 32, 1882.)

The Irrigating Curette and Spoon.—Dr. M. B. Freund of

Breslau describes this instrument in the *Centralblatt fur Gynakologie*, No. 35, 1882. It is formed exactly like the ordinary curette or spoon, but hollow. At the lower end of the handle is an olive-shaped knob, over which the thin-walled rubber irrigation-tube is slipped. The principal use of this instrument is, of course, to secure prophylactic antisepsis, and further, if necessary, to arrest hemorrhage during the operation of curetting, inasmuch as, during and after the operation, the morbid surface is bathed with antiseptic or styptic solutions. In all cavities (uterus, rectum, nose, or a fistula), by the use of the ordinary curette, a simultaneous irrigation cannot be attained from the want of necessary space for another instrument. The importance of antiseptic irrigation during the operation of curetting such surfaces is obvious, seeing that they usually contain putrid secretions or fragments of tissue, which, under the pressure of the instrument, may easily gain access through the numerous freshly opened portals to the general circulation.

The Etiology of Uterine Displacements and Distortions (Flexions.)—This is the title of an article by Dr. Graily Hewitt of London in the July number of the *American Journal of Obstetrics* for this year. For some years Dr. Hewitt has taken particular pains to ascertain the cause of the cases of displacement coming under his care. He has found it possible, in a good many cases, to trace in the previous history particular causes to explain the occurrence. He has been struck with the fact of how frequently the particular cause of displacement or distortion proved to be some external mechanical, physical injury. From the history of cases sent to me for treatment by physicians, I have formed the opinion that the frequency of operation of such causes is not as generally appreciated by the profession as it deserves to be, and it is with a view of drawing the attention of our readers to this subject that I have embodied the substance of Dr. Hewitt's paper in my report for this month. The author found that of 340 cases of sterile married or single patients, 43 per cent. were distinctly traceable to some mechanical exciting cause. Strains from efforts in lifting or nursing sick relatives were common causes—62 out of 149 cases. They most com-

monly produce the effect in persons who undertake such exertions without proper training or strength. Lifting, or occupations involving much standing, are responsible in many cases. "Stretching up to a cord," "drawing the cork of a bottle," "carrying a child," "strain at archery," "moving furniture," "rowing," "use of sewing machine, "lifting a patient from the ground," "lifting wash-stand," were the causes traced in other instances. Unnecessary gymnastic feats, excessive standing at croquet, one or two cases traceable to excessive swimming, may also be mentioned. "Falls" or other accidents include many cases in the tabular list above given. "A complete somersault down a flight of steps," "thrown from a carriage," "thrown from a horse," "fall from a horse," "falls on the back on the ground, down stairs," etc. Under the foregoing heads I find cases of retroflexion recorded. "Jump from a carriage," "slipped down stairs," "fall down steps," "jump from a horse," "fall from a horse," and "horse rolled over her,"—under these heads cases of anteflexion could be quoted. Horse exercise was clearly traced as a cause in several cases. In one case it indirectly led to displacement, owing to prolonged retention of urine. In weakly young women, imperfectly trained to it, horse exercise appears decidedly injurious. Over-walking includes several cases. "Long mountain walks," "daily long walks," and "long walks to catch a train," are causes traced in some retroflexion cases. "Long walks up hill," "very fatiguing walk," "walk during menstrual period," etc., in certain cases of anteflexion. Organ or harmonium playing was found injurious in a few cases. Retention of urine during long railway journey, fright, etc.,—these cases require no particular mention. There were fourteen cases in which the cause assigned is measles, scarlet fever, or typhoid fever. The reason for introducing these causes is, that the cases on investigation proved that the uterine affection had occurred from ordinary walking during convalescence from fever. The conclusion formed was, that the uterus, enfeebled in common with the other organs of the body, gave way under ordinary exertion, and the preceding fever was thus really responsible for the resulting uterine affection.

The author draws attention specially to some of these causes. He has notes of a considerable number of cases of severe injury to the uterus from strains, falls, and railway or carriage accidents. At the time of the accident the injury is not usually made out, but later, inquiry and examination reveal the distortion or displacement. Horse exercise may cause flexion of the uterus. It may be produced suddenly and at once, or more gradually. It is not so liable to happen if the individual be strong and properly trained to it; but evidence that could be adduced seems to show that it is a kind of exercise not free from danger of producing serious uterine mischief, even when judiciously managed. The evidence shows that the uterus is liable to be pushed downwards on the floor of the pelvis, and generally very decidedly flexed backwards or forwards. If there be no particular predisposition to flexion, horse exercise may do no harm, but it is never certain that it will not. Severe flexions of the uterus, as well as other injurious results, often ensue from standing a long time, as in the case of shop-women. Laundry work also very frequently produces similar results.

Marriage, also, Dr. Hewitt asserts, must be mentioned among the causes of flexion. In cases where there is a predisposition to flexion, and where the uterus is soft and weak, intercourse has often a very prejudicial effect, and marriage in such cases may lead to troublesome disease of the uterus in consequence of mechanical disturbing influence thereby brought to bear on the organ.

Eucalyptus Globulus in Gynæcological Practice.—Dr. A. F. Currier of New York, in a short paper in the *American Journal of the Med. Sciences* for the present month, gives the results of a trial of this drug at the New York State Woman's Hospital. The trial was made in the service of Dr. Jas. B. Hunter at the time that Dr. Currier was house surgeon. The preparation used was a mixture of equal parts of fluid extract of eucalyptus and glycerine. Dr. Hunter has, however, used the undiluted and unmixed oil in private practice, and with satisfactory results. It has long been known that this drug on mucous membranes in general, is stimulant, astringent, and antiseptic. Hence a wide

variety of uses was suggested, as in diphtheria, lung affections, gonorrhœa, and in inflammations of the mucous membranes of bladder, vagina and rectum. The cases in which it was used under Dr. Hunter at the Woman's Hospital were cellulitis, prolapsed, painful, and congested ovaries, and displacements with adhesions. It was applied on cotton-wool pledgets, with which the vagina was lightly tamponed. This was repeated daily, or nearly so, for weeks; half an ounce of the preparation being used at each time. The results in the five cases reported were very decided in relief to the pain and other symptoms. In no case could it be claimed that cure was effected, but the remedy was proved to be a most valuable anodyne in a class of affections in which we have a very small number of remedies that are of value.

Retention of the Head of a Mature Child, together with remains of the Placenta, in the Uterine Cavity for Forty Days without Symptoms.—A contribution to the subject of the tolerance of the uterus to traumatic and septic influences, by Alois Valenta of Laibach. (*Archiv f. Gyn.*, Band XVIII. Heft 3.) This was the case of a healthy, well-developed woman, aged 35, the mother of four children, who was brought to the Laibach Obstetrical Clinic. The child presented by the shoulder, a physician was sent for, he turned, and, after great difficulty, delivered the body of the child; and as he did not succeed in delivering the head, he cut it off, leaving it in the uterine cavity. Two other physicians were called, but neither did they succeed in delivering the head. No vaginal injections were used till the eighth day, when a midwife was employed to inject warm water two or three times a day for several days subsequently. Notwithstanding this neglect, she had no rigors or abdominal pain; the functions of bowels and bladder were healthily performed; appetite and sleep were normal. The only symptoms complained of were weakness and an offensive vaginal discharge. After admission to the clinic, vaginal injections of carbolized water were administered. There were no evidences of uterine contractions. The uterine tissue was represented by a thin layer stretched over the head. The local and general conditions indi-

cated that involution of the body of the uterus had proceeded as far as possible under the circumstances, while that of the cervix appeared to be complete—a condition quite unfavourable for the extraction of the retained fœtal head. The cervix was dilated with sponge and tupelo tents, ergot was given in large doses, and by means of a polypus forceps the head was broken up and extracted piecemeal, after the patient had been chloroformed. It was, however, necessary to incise the external os on both sides before the parietal bones could be extracted, as a laceration was imminent. During the process of extraction of the cranial bones, portions of tolerably fresh-looking placenta came away, and when the uterus was otherwise empty, a piece of the size of the palm of the hand was discovered and removed. During the operation, three per cent. carbolized intra-uterine injections were repeatedly employed, and at its close a subcutaneous ergotine injection. The subsequent course of this case, the patient's second puerperium of one pregnancy, was entirely favourable. There were absolutely no unfavourable symptoms.

In his remarks upon the case, the author justly claims that it is very extraordinary in two respects: 1st, The tolerance of the uterus of a foreign body (as the head must be considered to have become) without any tendency to expel it; and 2nd, The absence of any septicæmia under such circumstances. With reference to the tolerance of the uterus of substances of this description, it is to be remarked that there are a few cases on record. Liebmann has industriously collected a few cases, which he has published in the *Beitrage zur Geburtshülfe und Gynakologie*, Berlin, 1874, Bd. III, s. 47. Freund also (*Deutsche Klinik*, 1869, Nr. 33) reports the case of a woman in whom the head of a child was retained within the uterus for ten years. As regards the second remarkable fact, the absence of septicæmia in these cases, the fact is pertinent to the question of the value of antiseptic intra-uterine injections when the lochia are offensive. When we reflect on the fact of how often a dirty finger or instrument is sufficient to carry the death-warrant to a woman in labour and after delivery, and compare these cases with those of the nature just related, we are forced to the con-

clusion that there are other conditions necessary to the setting up of septicæmia besides the presence of septic material. Dr. Valenta accounts for the remarkable immunity of his patient by the original tetanic contraction and progressive involution of the uterus. The uterus was thus so firmly and tetanically contracted over the head that no air or gas could be accumulated between it and the skull of the child; and, further, the occipital foramen of the child was applied near or directly over the os uteri, so that the putrid diffluent brain matter escaped without any opportunity for contact with the interior of the uterus.

Acceleration of Labour: A Contribution to our Knowledge of Eclampsia.—This is the title of a paper by Dr. F. Schauta in a recent number of the *Archiv fur Gynakologie*. Dr. Schauta is assistant at the clinic of Professor Späth of Vienna. The paper gives statistics based upon the large number of 134,345 labours, among which 344 cases of convulsions occurred. Figures are furnished bearing upon many points in the natural history of this disease, which are of much value, and deserve the attention of specialists. *Convulsions* coming on *during* pregnancy quite as often, according to Dr. Schauta, persist during labour, *as cease before* that process begins. The commonly received opinion that convulsions first attacking the patient during labour commonly cease when delivery is complete, Dr. Schauta finds to a great extent negatived by the facts he has collected. The practical point, says Dr. Schauta, which springs out of these results seems to be this: that in labour complicated with convulsions, the accoucheur should not allow himself to be persuaded into operative delivery unless the clearest indications exist and the necessary conditions are present, and that the *accouchement forcé*, now on other grounds rightly abandoned, should, looking at the prognosis of puerperal eclampsia, be unconditionally condemned. The author tests this conclusion by analyzing the cases according to whether labour was artificially induced or not. Of the 42 cases of convulsions occurring during pregnancy, 20 were delivered spontaneously, and 21 by the help of the accoucheur; the remaining one passed from observation undelivered. Of the former, two

died, or 10 per cent.; of the latter, 19, or 90.4 per cent. These 19, however, include five who were delivered by Cæsarean section after the death of the mother. The subtraction of these reduces the mortality to 87.5 per cent. It will, of course, be obvious that the cases in which interference to effect delivery was resorted to were in all probability the worst cases, and the enormous difference in the result between those left to nature and those delivered artificially is probably for the most part to be accounted for in this way. But admitting this, it is also evident that the acceleration of labour did not do very much for the patients. The result shown by cases of convulsions coming on during labour is much the same. There are, however, two good reasons for hastening delivery—if we can do so without doing harm. The first is, that by emptying the uterus, the intra-abdominal pressure which, in the large majority of cases, is a main cause of the kidney changes which produce eclampsia is reduced, and therefore the earlier the delivery takes place the earlier the recovery may be expected to begin. The second is, that the sooner the delivery is effected the better chance the child has of survival. The risk to the child, as well as to the mother, Dr. Schauta shows, is in proportion to the number of the fits. The prognosis for the child is, as, perhaps, might be expected, worse when the fits come on before, than when they commence during, labour. The infantile mortality among the cases of the former class which Dr. Schauta tabulates was 41.8 per cent.; among those of the latter, 20.5 per cent. In considering, in the light of these figures, whether in eclampsia delivery ought to be hastened, the question naturally occurs, whether the bad results enumerated may not have been the result of an aggravation of the nervous condition by the operation necessary to effect delivery, *i.e.*, whether operative delivery *per se* has any influence in producing convulsions. Dr. Schauta has, with this point in mind, analyzed the cases in which eclampsia appeared after labour. He finds that 74 of these had been naturally delivered, of whom 19 died, or 25.6 per cent.; 8 had been delivered by operative aid, of whom 2 died, or 25 per cent., a proportion nearly the same. These figures seem to

us of considerable practical moment. It would be going too far to regard the high mortality among those who were delivered by art as due solely to the mere fact of interference. It seems to us largely explained by the consideration that the cases in which this treatment was resorted to were probably the worst; and it may also have been sometimes the case that the state of the patient led the medical attendant to hurry delivery more than he would have done had death seemed less imminent, and in doing so, to inflict damage which might have been avoided had less haste been used. If pregnancy has anything to do with the causation of the disease in question—and that it has, we think, there cannot be a doubt—we might expect that the removal of so powerful a cause would favour recovery. But Dr. Schauta's cases show this: that there is no such immediate advantage as to justify us in running any risk of other dangers for the sake of speedily ending the pregnancy. If labour has begun, or if it has been induced, it is best left to take its course with the minimum of interference. It seem to us still an open question whether labour may not be induced with advantage, provided the process be conducted in a manner as closely as possible approximating to that of nature; but whether induced or at the natural term, such interference as would be called for if there were no convulsions is alone that which is required. Everything further is submitting the patient to unnecessary risk without any compensating advantage.—*Med. Times and Gazette*, Sept. 2, 1882.

Hospital Reports.

MEDICAL AND SURGICAL CASES OCCURRING IN THE PRACTICE OF THE MONTREAL GENERAL HOSPITAL.

CASES UNDER THE CARE OF DR. RODDICK.

(*Clinical Clerks*—Messrs. J. B Howard and Scott.)

CASE I.—*Enlarged Bursa Patellæ treated by Antiseptic Puncture.*

J. E., æt. 38, was admitted June 10th, 1882, complaining of enlargement over the right knee cap, and which was readily diagnosed as *bursitis*. It appears that about two months pre-

vious to admission he was thrown forcibly against an iron post, striking the right patella. Effusion followed very slowly until it reached its present dimensions, namely, the size of a goose's egg. The enlargement is slightly tender on deep pressure, but there is about it neither heat nor redness; it is distinctly fluctuating. Immediately on admission the patient was placed under the influence of ether, and (under the spray) a puncture made into the sac on the outer side. Over an ounce of clear bursal fluid, containing a few flocculi, was withdrawn. About a dozen threads of the coarser catgut were then introduced into the cavity and made to protrude through the wound. The whole was dressed antiseptically, and the limb placed on a back splint.

June 16th.—The dressings were removed to-day, and the wound found perfectly closed, the catgut having been absorbed at the line of the skin. There was no sign of the bursal enlargement. The antiseptic dressings are ordered to be discontinued, and a flannel bandage, with pad over the patella, substituted. He was discharged cured on the twelfth day after admission.

Remarks.—This method of treating housemaid's knee and bursal enlargements generally, will be found invariably satisfactory. Care should be taken to introduce the catgut well into the cavity of the bursa, otherwise the cure may only be temporary. I would suggest that, if the spray be not available, the incision be made either under water charged with carbolic acid, or that a stream of one to forty solution be projected on the part during the operation. This will prevent the ingress of impure air and subsequent pus formation.

CASE II.—*Lupus Exedens of the Face treated with Volkmann's Spoon and the Gas Cautery.*

M. P., aged 20; married; comes of a healthy family, and knows of no similar case among her relations; has had three children at full term; last confinement one month before admission (Jan. 31st, 1882.) Had eczema when a child.

The present attack began eighteen months ago as a small "button," just in front of the tragus of the right ear. This was

round, hard, of a dull red colour, and when scratched bled a little. It enlarged considerably, then gradually healed, and as it healed other spots appeared around it, and went through similar stages. Lately, however, due probably to the puerperal condition, the ulcerating process has far outstripped the healing, and we now find the whole of the right cheek and temple involved. In places, within the zone, are to be seen evidences of cicatrization, with here and there tubercular nodules, which have not yet broken down. There is no tenderness, pain or itching about the eruption, nor can any enlarged glands be felt about the face or neck.

Feb. 2nd.—Ether was administered and Volkmann's spoon used to scrape away any tissue that could be thus removed. Paquelin's thermo-cautère was then freely applied to the scraped surfaces. Lead lotion ordered for 24 hours, and subsequently poultices of linseed meal.

Feb. 6th.—Patient has had a considerable amount of pain, but the temperature has not been affected, and her general condition is excellent. The sore looks well, the sloughs having nearly all separated. Water dressing is to be substituted for the poultices.

Feb. 10th.—She insisted on leaving the hospital, and is given a mixture containing five minims of Fowler's solution in each dose, and an ointment of iodoform to be applied to the sores.

This patient returned subsequently under Dr. Fenwick's care, who repeated the scraping and cauterizing operation to some small spots of a suspicious nature, but at present (Aug., 1882), there is no evidence of disease remaining, the affected area being covered with a firm and apparently healthy scar.

Remarks.—Lupus of this form is now invariably treated in the Montreal General Hospital, after the method just described, and when the operation is performed with care and thoroughness a cure is certain to follow. Arsenic and cod liver oil are indicated in some cases, but the local treatment is most to be depended upon. For the scraping process to be effectual, the spoon must be used freely, especially about the edges of the ulcerated spots, removing all tissue soft enough to be broken

down by it. The cauterizing is intended to complete the work of destruction, and is probably, in many cases, an unnecessary procedure.

Reviews and Notices of Books.

De la Lithotritie Rapide.—Par le Dr. RELIQUET, Laureat de l'Institut, Vice-Président de la Societé de Médecine de Paris, &c· Paris: Adrien Delahaye. 1882.

La Lithotritie Sans Traumatisme.—By the same author.

Dr. Reliquet is no mean authority on the subject of genito-urinary diseases; in fact, we understand he is almost as favourably known in this connection among French surgeons as Sir Henry Thompson is in England: hence anything from the pen of Dr. Reliquet is usually hailed with delight by the profession. In the papers before us, however, we fail to find any hint or suggestion on the subject of rapid lithotrity of very practical importance. In fact, though Bigelow's original instruments are figured and described, the author does not appear ever to have used them, and nothing is said of their more recent improvements. The author has a theory regarding the relative position of the stone and body of the patient during lithotrity, which he is evidently anxious to develop. He maintains that the patient should be so placed that the instrument shall at once seize the stone on entering the bladder, and, to that end, advises the use of a special apparatus, which, placed under the patient's buttocks, can be made to raise the pelvis to any desired height and to rotate it. Dr. Reliquet figures a lithotrite of his own invention —*brise-pierre à pignon*—for which it is claimed that it cannot possibly become clogged with *débris*, on account of the projecting character of the male blade. The author is opposed to "aspiration" in many cases, preferring to rely on large and repeated injections of carbolized water for the removal of fragments through a large-eyed catheter. He thinks that this water does good, besides, in soothing the mucous membrane of the bladder and cauterizing slightly bruised points. When the expulsive power of the bladder is deficient, however, he uses an

aspirator, preferring Thompson's to Bigelow's. After each operation Dr Reliquet throws a solution of boracic acid into the bladder, to be left there.

The papers are carefully written, full of excellent woodcuts, and altogether well worthy of perusal.

On Diet and Regimen in Sickness and Health, and on the Interdependence and Prevention of Diseases and the diminution of their fatality.—By Horace Dobell, M.D., Consulting Physician to the Royal Hospital for Diseases of the Chest, Consulting Physician to the Royal Albert Orphan Asylum, &c. Seventh edition, revised and enlarged. London: H. K. Lewis.

This excellent book of Dr. Dobell, which has passed already through several editions, is one which deserves to be better known in this country. The supreme importance of dietary and regimen both in health and in sickness is becoming daily more fully recognized. The author is one who is best known by his writings upon physiological subjects connected with the digestive system and upon pulmonary consumption. After considering what should constitute a normal diet in a healthy adult person, he goes on to formulate the principles which should guide us in arranging a dietary for sick persons. A great many useful recipes are given, sanctioned by his own experience. This leads to the second division of the work—the interdependence and prevention of diseases and the diminution of their fatality. In connection with the matter of diet, the subjects of anæmia and fatty degeneration, &c., are very well and philosophically treated.

The Illustrated Quarterly Journal of Medicine and Surgery.—Edited by Geo. Henry Fox and Frederick R. Sturgis. No. III. July, 1882. New York: E. B. Treat.

This number maintains the high standard of the previous ones, both in the character of the illustrations and the quantity of the subject matter. The first paper, by Dr. F. W. Campbell of Montreal, is on a case of duodenal ulcer, which is accompanied

by a beautifully-executed plate from a coloured drawing by our well-known artist, Mr. Wm. Raphael. Dr. McBurney describes and figures a new method of closing urethral fistula. Three coloured figures illustrate Congenital Keratoma, Papilloma of the Pharynx, and Gummous Iritis. Dr. Chamberlain writes on the therapeutic uses of rubber tubing, and numerous cuts are given illustrating the mode of application to different parts. Dr. M. J. Roberts advocates the use of elastic tension in the treatment of Potts' disease.

The Transactions of the American Medical Association. Vol. XXXII.

We have received the above volume, which contains the report of all the proceedings of the meeting held in Richmond in May, 1881. Many of the papers have, of course, appeared in the medical journals shortly after their delivery, but, at the same time, it is extremely useful to have in library form the complete collection. This volume is quite equal to any of its predecessors in the variety and value of the articles it contains.

Books and Pamphlets Received.

The Diseases of the Rectum. By William Allingham, M.D., F.R.C.S. Fourth edition. Philadelphia: P. Blakiston & Co.

A Practical Laboratory Course in Medical Chemistry. By John C. Draper, M.D., LL.D. New York: Wm. Wood & Co.

Nitro-Glycerine as a Remedy for Angina Pectoris. By Wm. Murrell, M.D., M.R.C.P. Detroit: Geo. S. Davis.

Transactions of the Michigan State Medical Society for the Year 1882. No. 2. Vol. VII. Lansing: W. A. George & Co.

The Multum in Parvo Reference and Note Book. By C. Henri Leonard, M.A., M.D. 14th thousand. Price 30c.

Essentials of Vaccination and on Smallpox. By W. A. Hardaway, M.D. Chicago: Jansen, McClurg & Co.

The Physician Himself and what he should add to his Scientific Acquirements. By D. W. Cathell, M.D. Second edition. Baltimore: Cushings & Bailey.

Extracts from British and Foreign Journals.

Unless otherwise stated the translations are made specially for this Journal.

Effect of Bleeding on Inflammation.—The effect of local abstraction of blood in relieving local inflammation is one of the ancient doctrines of therapeutics which is still unrefuted. and still unexplained. It was formerly held that the result was produced by a perfectly simple *modus operandi*. By the removal of blood from the surface the vessels of the deeper inflamed parts were partly emptied; but it was later recognized that this explanation is incompatible with the known conditions of the circulation. The local removal of blood never produces a lasting effect on the circulation in the part. At the present time it is generally assumed that the effect of local depletion is to remove the inflammatory stasis, although such an effect has never been demonstrated experimentally; and, moreover, the idea of a derivatory action still haunts the theory of the subject, while the effect is sometimes ascribed to the influence of the depletion on the whole mass of blood. The question has been lately subjected to experimental investigation by Genzmer and Nikolas, of Halle, and the results obtained have been described by the former in the *Centralblatt für Med. Wiss.* In the web of the foot of curarized frogs foci of inflammation were excited by punctiform cauterization, either by nitrate of silver or a red-hot needle; and the process was watched with the microscope. When well-known phenomena of inflammation made their appearance, the aggregation and exit of the white corpuscles, retardation of the blood current, and, finally, the formation of stasis, a leech was applied to the leg. As soon as the leech began to suck, a striking change occurred in the inflammatory process in the foot; the blood current became quickened, and carried on the corpuscles which were adherent to the wall. The stasis passed away, and in a few minutes the inflamed capillaries were cleared, and presented to the end of the experiment a normal and even accelerated circulation. Whether the corpuscles which had already wandered out of the vessels were influenced by the abstraction of blood could not be determined with certainty. In some experiments

scarification was employed after the focus of inflammation had been excited. The effect was less conspicuous, since the loss of blood did not occur with the same vehemence as with a leech, although the amount of blood abstracted was nearly the same. The effect of abstraction of blood from the general circulation, by opening an abdominal vein, was still slighter, although the amount of blood taken was considerable. The conclusion drawn from these experiments is that the antiphlogistic action of local abstraction of blood is produced by a purely mechanical agency. A temporary augmentation of the circulation occurs, by which the capillaries are cleared; and the stasis, which is the first step in a local necrosis, is removed. Not only is no local anæmia produced, but there is actually an arterial hyperæmia; there is an increased supply of arterial blood to the focus of inflammation, which, besides its effect on the blood vessels, may reasonably be supposed to improve the nutrition of the tissues, and so to counteract the tendencies of inflammation. The antiphlogistic action is clearly proportioned to both the amount of blood withdrawn and to the rapidity of its withdrawal, and its action is notably greater when blood can be withdrawn from the circulation between the region of the inflammation and the right side of the heart.—*Lancet.*

Dry Gangrene from Local Application of Carbolic Acid.—(J. B. Garrison, M.D., Garretson's Landing, Ark.)—About the middle of February last, a daughter of Dr. Childress, of Williamette, Ark., consulted her father as to an onychia in process of development on her right index finger. She was directed to "apply carbolic acid," but instead of applying a few drops to the affected part, she wrapped the entire finger as far as the second joint with several folds of linen and poured on it to saturation pure carbolic acid, liquified, and allowed it to remain in *statu quo* all night. Next morning the bandage was removed, and on the third day after the occurrence, when I first saw it, the finger as far as the second joint was as black as jet, cold, perfectly anæsthetic, wrinkled and shrivelled, with sulci apparently clinging to the bone; hard as wood; in a

word, actually mummified, with a line of demarkation entirely around the finger, indicating a complete separation of the dead from the living tissue. Although there seemed no possibility of saving the finger, as it had actually lost every vestige of vitality, yet I directed a small rubber band to be tied around the finger, near the metacarpo-phalangeal articulation, sufficiently tight to obstruct the reflux of venous blood without repressing the arterial supply. This was applied for five or ten minutes every hour and kept up continuously for more than two months. The tissues of the finger gradually yielded to the mechanical pressure of the blood, and the digit resumed its shape and functions, except that it was entirely denuded of integument. The old skin was allowed to remain as a protective, and warm, moist poultices, with oil and glycerine, were constantly applied to soften the tissues. The fortunate result of this case is an additional argument in favour of the principle of conservatism in surgery which should obtain in all similar cases.—*Western Med. Reporter.* [Several cases similar to the above have been recorded during the past two years, in which carbolic acid locally used has produced a condition closely resembling dry gangrene. In none of these cases, however, was any attempt made, if we remember correctly, to save the parts. Dr. Garrison's success in his case will lead to a more active line of treatment in the future.—B.]

On Cases showing the Utility of a Laminated Plaster Splint.—We have now in the wards, and always have had during the last few years, several cases showing the use of a simple splint—a splint so simple, that I think we may not inaptly call it the universal splint. I will tell you in a few words what it is, and go more into details afterwards. Take a few sheets of muslin, put them one over another, spread plaster-of-Paris between them, roll or fold up this "layered" sheet in any convenient form, dip it in water a few moments, lift it out of the water and very gently squeeze it, spread it out neatly and smoothly, and you have a soft sheet of splintage ready for any purpose which splints can secure. This

sheet may be little or big; it may envelope a finger or a limb, or the trunk, or the trunk and the head, or the trunk and the lower limb. It is simply drawn under the part, and folded over it. The drawing under, the folding over, and the trimming by means of scissors, are the work of a time measured by seconds. The part is kept in one unaltered position by intelligent force until the sheet sets—a time measured by minutes. A firm, durable and perfectly fitting splint is thus obtained, which may be left on for weeks or months.

Here is a woman who came in with a tucked knee, the result of joint-disease of some standing. The knee was flexed at a right angle, and the head of the tibia was slightly displaced backwards. Under ether, and by a contrivance to which I shall refer again, we straightened the knee. A prepared laminated plaster splint, having been dipped in water and unfolded, was drawn under the limb, folded over it, and allowed to set before the extending forces were relaxed. In another ward, we shall see a fractured femur treated by a similar method; the pelvis, thigh and upper part of the leg being enveloped in a layered plaster splint. All our broken thigh-bones are treated in this way, with this signal advantage—we get them up on crutches in a fortnight. Our broken tibiæ we got up in a few days. Some of you have recently seen a case of osteitis of the wrist enveloped in a laminated splint, a hole in which let the thumb pass through. This layered plaster splint is, in principle, the exact opposite of the plaster roller. For the lower limb, especially for the lower limb and pelvis, the unrolling of plaster bandages is a slow and tedious proceedings, and necessitates many movements and many positions. The principle of lamination or stratification in the construction of plastic splintage may, with suitable change of detail, be extended to other materials; but I have hitherto found the checked muslin and thinly spread plaster in superimposed layers the most generally useful—useful in fractures, joint-diseases, spinal diseases; useful, in short, wherever rest, immobility and support are needed. The laminated plaster splint is quickly and easily made. The surgeon first determines how much of the limb or trunk it is well to

cover. A pattern is then cut. One of the layers of checked muslin does very well for this purpose, as it is stiff enough to keep its shape, and is easily marked with a pencil. Afterwards, other pieces of muslin are cut of the same size and shape. Six or seven layers make a good average splint; three or four will do for a child; eight or nine may be needed for a heavy, restless or delirious patient. The first layer is laid flat on the table, and sprinkled with a stratum of good dry powdered plaster, which is smoothed over with a spatula or paper-knife; on this, with its margins corresponding, is placed the next layer of muslin, which in its turn is sprinkled with plaster. The process is repeated until all the layers are in place. The splint is then slowly and carefully folded or rolled up and kept dry, ready to be dipped in water when wanted. The water—let this be well understood—immediately passes through any number of layers of muslin and plaster, thoroughly drenching them both in less than sixty seconds. The part to be encased is drawn into position, and held so until the plaster partially sets. If the fingers of the extending hand be in the way, as when the foot is included in the splint, a temporary sling of webbing or plaster over the instep and heel may be used, which can be drawn out or relaxed afterwards. A flannel bandage, or layer of wadding or jersey, is next applied without traction. The splint is now dipped in hot water (hot for comfort and for more rapid setting) for a minute or so. When taken out, it is very gently squeezed, being quite sloppy and limp. When the water is pressed out too freely the sheet will be sandy, friable and difficult to apply. The splint is then unfolded, and drawn out in a perfectly smooth and soft sheet; it is next put under the ailing part, and simply folded over. The overlapping margins instantly and firmly adhere to each other. Traction should be most carefully avoided; perfect neatness is enough. The layered plaster splint is applied with as much ease, as regards limpness and adjustability, as is a fomentation; but it is a fomentation which sets, and, with rock-like firmness, lastingly holds the part in any given position. In the upper limb, the laminated limb sheet should be large enough to overlap two or

three inches; in the lower limb, the overlapping should extend to three or four inches; in the trunk, to five or six. A pair of strong, sharp scissors easily trims the splint while it is still wet. Redundance may be now curtailed, or windows made. To get a neat fit opposite joints, especially flexed joints, as the elbow and ankle, the margins of the splint may be notched at each side, or V-shaped bits may be cut out. The corners of a paper box suggest methods of dealing with the elbow. Windows may also be made. and redundancies curtailed very readily, by means of a sharp scalpel, when the plaster is partially set. When the splint is quite dry, a Hey's saw may be used. When it is wished that a sixth or fourth of a whole limb shall be visible, a longitudinal strip is easily removed with a knife in the early setting stage—a stage which lasts long enough for any desired degree of carving. Windows, scollops or openings of any kind do not weaken a splint; and it is better to make them opposite bony prominences, breasts and other compressed parts, as well as opposite abscesses, wounds and compound fractures. If it be desired, a sheet splint may be put on at first, so as to leave a longitudinal strip uncovered. If so, a separate outer layer of muslin must be large enough to overlap, and be fixed with a row of pins for a few minutes. I have adopted this method several times; but I much prefer the overlapping method for ease of application and for efficiency. If, in rare cases, an exposed strip be desired, the carving method in the setting stage is preferable. In the upper limb, a gaping longitudinal splint may be conveniently held in place by a few turns of bandage until the setting is firm. It is convenient, in making a very large splint, to envelop, say, the trunk, or the pelvis and the lower limb, to put it on in two or three pieces made to overlap each other. Where the layered pieces overlap, they amalgate and form a perfectly homogeneous and continuous splint. I will now describe the method of putting on the laminated splint in a few of its more simple but most useful applications. I begin with a simple method of applying a plaster jacket. It may be put on under the tripod—an advantage when the tripod is needed. I usually adopt the horizontal posture, as

advocated by Dr. Walker. Three layered pieces, averaging about thirty-six inches by seven or eight inches, are prepared. These three rolls are easily packed, and may be carried any distance. If any suspicion of dampness exists, hold them over a fire a few minutes in a frying-pan lined with a newspaper. Marks having been previously made on the mattress opposite the axilla and the trochanter, the pieces, when taken out of water, are so arranged that the patient, sitting in readiness, lies down upon them. The middle piece is neatly and leisurely folded over the trunk (encased in a jersey) first; next, the lower and upper pieces are folded over, their margins freely overlapping the central piece. The upper and lower pieces are so applied as to make a waist—the overlapping ends of the upper piece tending upwards, the ends of the lower piece tending downwards. It might be naturally feared that the margins of the pieces would be sudden or prominent. On the contrary, the margins are graduated; and, if the water have not been pressed out too freely, the continuity of the splint is so complete that they cannot be found. The armpit and groin portions should be quite freely cut out when the plaster is partially set. The plaster sheet-splint for fractured femur and for hip-disease is also put on in three pieces, and, when applied, forms one continuous splint, embracing the pelvis, the thigh, the knee and the upper part of the leg. The piece first put on embraces the upper part of the thigh and the pelvis spica-wise, the ends crossing over the trochanter. Overlapping this, and fixing the ends, is the pelvic piece, which in size and position is similar to the lower piece of a spinal jacket. A third large and long piece overwraps the "spica" piece, and covers the thigh, knee, and half the leg. All these pieces are drawn under the patient, and put in place before any one of them is folded over. Moreover, the needed position is also obtained before the folding over begins. The margins of the third piece may need a cut here and there, to avoid wrinkling. The fixity is so complete that, as a rule, it is unnecessary to enclose the ankle and foot. In hip-disease, pulley extension (put on after the position is improved under ether, if needful), with a splint on the sound side, should restore

a good position before the plaster splint is put on. In due time, crutches and a patten on the sound foot may be used. This splint is cheap, durable and simple, and, to my mind, superior to Thomas's splint. Diffused pressure is better than the pressure of stems and bands. Perhaps the greatest utility of the laminated plint is seen in the treatment of knee-disease, especially in that state where chronic and persistent flexion exists. I straighten the tucked knee by a peculiar but simple method. Ether being given, extension is made from the ankle ; but, what is much more efficient, direct pressure is made on the knee by means of a long, broad strap of adhesive plaster thrown over the knee, the ends being passed through a hole in the table underneath the knee. As you see, I have here a table full of round holes, each little more than an inch in diameter ; but one or two apertures in an ordinary table will do. In keeping up good positions while sheet splints are setting, a peg or two stuck in suitable holes help to steady the extending hands. To return to the knee ; when the limb is enveloped in flannel, one assistant takes charge of the ankle, another has the strip of plaster (already fixed on the knee) in his care. A layered plaster splint, of sufficient size to embrace two-thirds of the thigh and two-thirds of the leg, is dipped in water, unfolded and smoothed, and drawn under the limb, the knee of which lies over the opening ; a slit is cut with sharp-pointed scissors in the sheet ; the adhesive strap is passed through the slit and the hole ; the limb is now gently but firmly drawn into position ; the knee-strap, with traction made under the table, doing the greater part of the work. The best possible position being obtained, the sheet is lastly folded neatly over the limb, and the position maintained until the plaster is sufficiently set. The assistant in charge of the knee-strap fixes it in a given position by drawing it tightly against the edge of the aperture. This knee-splint should be worn several months, and renewed from time to time until the knee is practically well. A slit in a plaster sheet in no way weakens it, and the principle may be usefully adopted in applying plaster splints elsewhere. In fracture of the elbow, a band thrown temporarily across the bend of the elbow, and

carried through a slit opposite the olecranon, readily keeps the parts in place until the sheet sets.—*Clinical Lecture by Mr. F. Jordan in the British Medical Journal.*

Oleoresin of Male Fern: Increasing its Efficacy against Tapeworm.—According to E. Dieterich, the frequent failure of oleoresin of male fern as a remedy against tapeworm is to be ascribed to its irrational administration. It has become known that the popular "worm doctors," who use almost exclusively the oleoresin of male fern, and who hardly ever meet with a failure, administer the remedy in conjunction with castor oil, instead of following it by the oil after one or two hours, as is usually done by practitioners. The object is to bring the extract, in an unaltered or undigested condition, in contact with the worm. The experiments which have been made by mixing one part of the oleoresin with two parts of castor oil have been very successful, and this mode of administration deserves therefore the preference. Oleoresin of male fern is apt to derange the stomach, and when enveloped partly in the oil is likely to pass it more rapidly, which constitutes another advantage. The mixture has, it is true, an unpleasant taste. This may, however, be disguised by filling it in capsules of about three grams (forty-five grains) each. The dose may be regulated from six capsules (equal to six grams or ninety grains of the oleoresin and twelve grams of castor oil) to seven or eight more, according to circumstances. It is advisable to empty the bowels on the preceding day by a mild purgative, best by castor oil.—*New Remedies.*

Questionable Surgery: Oophorectomy.—The operation introduced by Dr. Battey is, unfortunately, being widely performed in this country. It is perfectly safe to assert that on no organ of the body are more doubtful operations performed than on the uterus and its appendages, and that in no department of medicine is the intellectual crippling of specialism more signally demonstrated than in that of obstetrics. Greed and the predilection engendered by special and limited study are apt to compel men to unravel all forms of disease,

from the standpoint of the particular department of which they may happen to have taken parental charge. This is daily illustrated in the experience of every practitioner who chooses to have his eyes and his mind open to conviction. Quite recently, at the Obstetrical Society of London, Dr. Braithwaite, of Leeds, read a paper "On Two Cases of Unilateral Oophorectomy," the first of which was performed for a *cardiac affection*, associated with dpspnœa! and the other for pain in the left ovarian region. We thoroughly endorse the remarks of the President—Dr. Matthews Duncan—on these cases, that "to remove one ovary as a treatment of cardiac dyspnœa he regarded as a wild proceeding; nor could he imagine that it ever could come within the range of rational medicine." Surely the unfortunate women thus operated on do not properly apprehend the nature of the operation to which they are subjected. It is not so long ago since obloquy and contumely were showered on an unquestionably able surgeon—the late Mr. Baker Brown—for the operation of clitoridectomy; we seem to have made rapid strides since then; yet, we have no hesitation in saying that in the cases indicated by Baker Brown, clitoridectomy was an infinitely more justifiable operation than oophorectomy. We hope to hear less of this barbarous operation in future. At the same time we would protest against the indiscriminate examination of women at public institutions before crowds of students as demoralizing to all concerned. At a certain *clinique* for women, in Scotland, we understand that the vast majority of women who present themselves are examined with the speculum in the presence of the students, and the *os* daubed with "iodized thymol" for all conceivable diseases. This disgusting and degrading practice should be circumscribed, not less in public than in private. It is saddening to reflect on the amount of mischief which is fairly chargeable to meddlesome surgery in the course of one single year.—*Med. Press.*

The Danger of Iodoform Dressings.—The search for an antiseptic body which shall be a powerful germicide, and yet not injurious when absorbed by the human

organism, still continues. Not long ago, Mikulicz, and many other surgeons in Germany, enthusiastically extolled the merits of iodoform; and it has been widely used both in that country and, though to a less degree, in this. For a time all seemed to promise well with the new drug, but gradually we began to learn its demerits; and recent experience seems to show that its use, under certain conditions, as yet not fully explained, may give rise to most serious, perhaps even to fatal results. Iodoform was introduced into England some years ago, as a local application which was of great use in the treatment of spreading ulceration, and especially of the local contagious ulcer. Gradually its use extended; it gained much favour with gynecologists, especially for the purpose of correcting the fœtor of ulcerating cancer of the womb; it was blown into the nose and into the ear, and, made up into a bougie, introduced into the male urethra. About two years ago, Mikulicz recommended it as a dressing after operations, major and minor, on the ground that it was a powerful antiseptic, and yet did not irritate the parts. Its employment was said to be especially advantageous in the treatment of scrofulous joints; and those who adopted this line of treatment did not hesitate to open freely a knee-joint affected with tumor albus, and introduce iodoform in large quantities into the cavity of the joint; in such a case, an outside dressing of cotton-wool, treated with iodoform, was applied, and left undisturbed for a month or more. No great care seems to have been taken to estimate the quantity of the drug used in such a dressing; it was ladled out of a bottle into the joint, and no ill effects appeared to follow. Now, Dr. Ringer pointed out last summer that iodoform was a heart-poison; he found that one-fifth of a grain would almost arrest the frog's heart. Such an experiment as this prepared us for the clinical observations detailed by Dr. Max Schede of Hamburg, who, in an important paper, published recently in the *Centralblatt fur Chirurgie*, drew attention to the toxic action of the drug. He found that, in certain cases, its use is followed by an enormous increase in the frequency of the pulse, which runs up to 180, even in the adult, without any marked rise of temperature, or any general symptoms beyond some disquietude,

malaise, and loss of appetite; in other cases, in addition to the rapid and feeble pulse, there are some fever and headache; in both of these classes of cases, the withdrawal of the drug is immediately followed by a disappearance of the symptoms. In other cases, where the rapidity of the pulse is very great, and the temperature very high (104°F. or more), the danger to the patient, in spite of the absence of marked general symptoms, is also greater—inasmuch as the withdrawal of the drug is not always followed by an immediate cessation of the symptoms. By far the most serious form that iodoform poisoning takes, however, is that in which the sensorium is deeply involved; in children the symptoms closely resemble those of meningitis, and have been frequently rapidly fatal, in spite of the immediate withdrawal of the drug. The child, who may have been in excellent health for some weeks under the use of iodoform dressings, suddenly becomes very ill, the pulse grows rapid, with irregular or perhaps very slight pyrexia, vomiting is severe, consciousness is disturbed or lost, and there are localized paralyses. It has been urged that probably, in Schede's cases, these symptoms did in reality depend upon a rapid meningitis—perhaps of a tubercular nature, for the patients have generally been strumous children; but this we do not believe to be a complete explanation, because, among other reasons, we are acquainted with a case of this kind which recently occurred in a London hospital, where symptoms pointing, as it was thought, most unmistakably to meningitis entirely disappeared when the affected joint was freed from iodoform. In Mr. Stanley Boyd's report of four cases, in the wards of University College Hospital, drowsiness and stupor were observed in two patients, symptoms of meningitis in one, and delirium in a fourth, which ended fatally. Both Schede and Küster say that the drug can cause sudden collapse and death; but of this there does not appear to be sufficient proof.

Iodoform is an iodine-compound, chemically analogous to chloroform; its composition is represented by the formula CHI^3; it contains therefore 96.7 per cent. of iodine. From this fact, it has been argued by some, wise after the event, that its use in large quantities must be injurious; but, what do we know of the

toxic properties of iodine itself? Very little, in fact. Iodine has been injected into the cavity of the pleura without ill effect, and, combined with potassium, enormous doses can be tolerated. Rather does the above account of the symptoms it can produce tend to approximate somewhat to chloroform in its therapeutics; and he would be a bold man who would maintain that the symptoms of chloroform poisoning were due to the chlorine in its composition. A writer in the May number of the *London Medical Record*, to whom we are much indebted, adopts the view of Dr. Mundy of Vienna, who contends that the toxic or fatal symptoms have been due to the reckless manner in which large quantities of the drug have been used. No doubt this is perfectly true; but it does not seem to explain all the phenomena. In the first place, it is comparatively rare to get any symptoms of poisoning at all. There are surgeons in this country who have used the drug in large quantities at a time, and have never met with a single case of poisoning; and in a great proportion of the cases reported, the symptoms did not appear until after the continuous use of the drug for two or three weeks. We are loth to fall back on Dr. Max Schede's theory of a peculiar idiosyncrasy; and, before doing so, we would certainly desire more complete observations, especially with regard to the urine. The supposed cumulative action of other drugs—of digitalis, for instance—has been distinctly traced to renal disturbances. So long as the kidneys perform their functions vigorously, so long is the poisonous substance rapidly eliminated from the blood, and gives rise to no symptoms; but if, from some cause, the urinary excretion is checked, then the poisonous body accumulates in the blood, and gives rise to its characteristic symptoms. For this reason we think that a careful examination of the urine, where iodoform is being used, may not only throw light on the way in which it produces toxic symptoms, but may also furnish a timely warning of their approach.

Lastly, we are informed that Prof. Kocher, of Berne, has been struck by the resemblance between the symptoms of iodoform and of chloroform poisoning, and that he has encountered one case where the onset of the symptoms was marked by signs of acute nephritis.—*Brit. Med. Journal.*

Pneumonia an Infectious Disease.—That acute, lobar, croupous pneumonia is considered by some an infectious fever, with evident tendency to the lungs, or as now better expressed, a zymotic disease, caused by the inhalation of bacilli, which accumulate mostly in a lower lobe of one lung, we have often had occasion to note. The proofs of this statement accumulate daily. Dr. Köhnhorn found that the disease had become endemic in one of the barracks at Wisel. Occasionally it broke out as a local epidemic. The regiment stationed there had suffered frequently from the disease. Not a year passed without many falling a victim to pneumonia. The regiment was then placed in other quarters, and no further case happened in this regiment. The barracks were torn down, the soil disinfected most thoroughly, as also the building material. Since the regiment has been camping in these rebuilt barracks not a solitary case of pneumonia has made its appearance.—*Phil. Med. and Surg. Reporter.*

Ear-ache.—Another way of stating that atropia paralyzes a peripheral sensory nerve is given by Dr. A. D. Williams in Martin's *Chemists' and Druggists' Bulletin.* He says what physician has not been puzzled to know what to do for the constantly recurring ear-aches of children at night? The most effectual treatment, and the one which has stood the test of years, is the local application of a solution of the sulphate of atropia. Not a single case but has yielded at once. The solution is to be simply dropped into the painful ear and allowed to remain there from ten to fifteen minutes. Then it is made to run out by turning the head over, then being wiped with a dry rag. The solution may be warmed to prevent shock. From three to five drops should be used at a time. The strength of the solution must vary according to the age of the child. Under three years, one grain to the ounce, and over ten years four grains to the ounce of water. In growing persons almost any strength may be used. All ages will bear a stronger solution in the ear than in the eye. The application should be repeated as often as may be necessary. Usually a few applications will stop

the pain. In acute suppurative inflammation of the middle ear, and acute inflammation of the external meatus, atropia will only slightly palliate the suffering, but in the recurring nocturnal ear-aches of children it is practically a specific.—*Chicago Med. Review.*

Iodoform in Chronic Pulmonary Affections.—Prof. Chiarmelli (*Giorn. di Clin. e Terapia et Gazz. Med. Ital., Prov. Ven.*, 1882), encouraged by the happy results obtained by Prof. Semmola with iodoform in the treatment of chronic affections of the bronchi, has experimented with this medicine during four consecutive years at the Hospital for Incurables, in many affections of the respiratory passages.

In phthisis, even at an advanced period of the disease with the presence of cavities, iodoform has given the author excellent results. In each case it diminished expectoration, and exercised a favorable influence upon the febrile manifestations. "Iodoform," he says, "diminishes the fever and affects the expectoration, which it not only diminishes in quantity but alters in character, preventing the putrefaction of its albuminoid elements. I am also convinced that the contents of the cavities in the lung exercise a powerful influence upon the production of hectic fever." In recommending iodoform in pulmonary phthisis, the author does not assert it to be a specific, but he claims that it arrests the march of this cruel malady and prolongs the life of the sufferer. He also holds that in cases where caseous pneumonia is commencing, iodoform administered for a time proves efficacious in arresting the progress of the disease. With many individuals affected with chronic bronchitis and emphysema, it renders great service. The formula which is employed is as follows:

Iodoform, - - - - -	grs. iss.
Powdered lycopodium, - - -	grs. viij.
Ext. of gentian, - - - -	q. s.

Make into 10 pilules. Take 3 to 5 in the day. If the dose is increased, gastric disorders supervene, and it is better to continue the above dose for a considerable time.—*Glasgow Med. Jour.*, August, 1882.—*Medical News.*

How to Demonstrate Tubercle Baccilli in the Sputum of Phthisical Patients.—Baumgarten recommends the following method as more convenient than that employed by Koch, and as equally efficacious. A portion of the sputum is dried on a cover-glass, and then treated with potash—one or two drops of a thirty-three per cent. solution of caustic potash added to a watch-glass of distilled water. The tubercle bacilli can then be readily seen with a magnifying power of four or five hundred diameters, from the enclosing detritus of tissue. In order to preclude the possibility of confounding the bacilli of tubercle with those of other species, the cover-glass may be raised and placed aside until the layer of fluid on its under surface is dry, and then passed two or three times through a gas flame, and then on it may be placed a drop of an ordinary watery solution of aniline voilet or any other nucleus-tinting preparation of aniline. All the putrefacation bacilli appear under the microscope as an intense blue or brown (according to the testing agent and its strength), while the tubercle bacilli remain absolutely colorless, and can be seen with the same distinctness as in the ordinary potash preparation. The whole process does not occupy more than ten minutes.

Curable Ascites of Alcoholists.—Ascites occurring among alcoholists is generally regarded as the result of hepatic cirrhosis, and hence incurable. In two patients Dr. Bouveret (*Lyon Medical*) has noticed a perfectly curable ascites. The first case was a man aged 45, who was a clear case of alcoholism. Following certain intestinal and gastric disorders a marked ascites made its appearance to which relief could only be given by tapping. The patient fully recovered after nine months of treatment. Bouveret brings this case and a second similar case which he reports into relation with the ascites which Murchison has reported as accompanying hepatic congestion, and Semmold has found to exist in certain cases of interstitial hepatitis and finally with the ascites found in chronic peritonitis by Leudet and Lancreux. Differential diagnosis is impossible, and only the progress of the affection can throw light on the nature of the ascites.—*American Med. Weekly.*

Should Babies' Milk be Boiled?—A correspondent, who has also contributed a letter upon this subject to the *Cincinnati Lancet and Clinic*, sharply criticises our recommendation given in a recent article, to boil the milk for children during the period when summer diarrhœa prevails, and expresses his unqualified preference for the plain article. As he apparently invites us to state our reasons, we will endeavor to do so, though not in a spirit of controversy, but simply because we are strongly convinced of the importance, if not the necessity, of the proceeding which we have recommended. In the first place, we cannot accept the statement that boiled milk is more difficult to digest than unboiled; on the contrary, as we have long been accustomed to rely upon it as the sole diet in cases of chronic diarrhœa of adults, in typhoid fever and convalescence from acute diseases, as well as for infants' food, experience has taught us that it is not true; we have failed to see it ever cause indigestion; on the contrary, as an article of food, have always found it bland and unirritating. Plain milk often forms large coagula in the stomach, and the masses are sometimes vomited and sometimes discharged from the bowels undigested; this is much less likely to occur with the scalded milk. In preparing the food of young infants, authorities generally agree that it should be raised a little above the temperature of the body. We advise that it should be raised considerably higher, and afterwards reduced to the desired degree, for reasons shortly to be stated. Milk is very complex and uncertain fluid. It easily undergoes a change of reaction, from sweet to sour, owing to the presence of the lactic acid ferment. It rapidly absorbs gases and odors, and, as has been repeatedly shown, it may thus act as a carrier of disease, by becoming tinted with emanations of zymotic affections like typhoid fever (Murchison), scarlatina (Bell), and diarrhœa (Wilson), etc. This danger is by no means slight; it is dwelt upon in many of our text-books upon children's diseases. Dr. Wilson, in his Hand-Book of Hygiene, speaks very pointedly with regard to it (page 53, third edition, Phil., 1877.) He says: "There can be no doubt that much of the infantile diarrhœa which proves

specially fatal during the summer and autumn months is due to milk which either becomes tinted in this way, or becomes tinted by being put into feeding bottles, which are seldom or never properly cleaned. Indeed, there are so many unseen dangers in the use of milk, especially among careless and filthy people, that, to ensure safety, *it should always be boiled* during warm weather." (Italics our own.) Dr. Day, the author of the latest English systematic treatise on diseases of children, also recommends that the milk be boiled. Meigs and Pepper speak in the highest terms of praise of a food for infants which requires the milk to be boiled; they find it to agree best with the children, who thrive upon it better than anything else they had employed. They say: "In several cases it has agreed well with infants who could not, without vomiting, diarrhœa and colic, take plain milk and water." J. L. Smith also speaks favorably of Hawley's and Liebig's Food for Children, which requires the milk likewise to be boiled, and observes that it agrees best with the digestion. It is not our desire to quote a long list of authorities in support of our statement that boiled milk is preferable to plain as an article of diet both for children and adults at the time of year when zymotic disease prevail, but those interested in the subject will find some of them given in detail by Day and Wilson, in the places quoted, as well as in Parke's classical work on Hygiene, and by many others that we need not mention.

When the experiments of Bollinger, of feeding milk from tuberculous cows to healthy calves and inducing tuberculosis, are borne in mind, we have an additional reason for submitting all milk to disinfection by heat, unless we know it to be from a healthy animal. Moreover, in the city, where the milk is from twelve to twenty-four hours old when delivered, and is well advanced towards acid fermentation, there is often nothing but Hobson's choice with regard to scalding it, if it is desired to keep the milk from one day to the next; and many families habitually boil the milk during hot weather, simply as a means of domestic economy.—*The College and Clinical Record.*

The Fillet in Breech Presentations.—Dr. Heinrich v. Weckbecker-Sternfeld, assistant physician to

the lying-in institution at Munich, contributes to a recent number of the *Archiv fur Gynakologie* a paper on the above subject. He points out that there are cases in which some help is required, in which traction by the unaided finger is inefficient, and bringing down a leg difficult and not devoid of danger. The blunt hook cannot be used without much risk of injuring the child; the forceps are apt to slip, and, indeed, can only get a hold by strongly compressing the pelvis. There are, therefore, cases in which traction by the fillet or loop is called for. The object of the paper, and our reason for quoting it, is to describe a new instrument invented and recommended by Professor Hecker, of Munich, for the purpose of getting the loop into position. It consists of a blunt hook having a very obtuse curve, somewhat that of a bladder-sound, and hollow from end to end. In this travels a steel spring, like that of Bellocq's instrument for plugging the nares. The tape (or strip of whatever material is preferred as a means of traction) is provided with a little pocket at one end, into which the extremity of the blunt hook fits. It is thus carried by the hook up on the outer side of the hip-joint, and over the fold of the groin. The spring running inside the hook is then pushed forwards, made to protrude from the end of the hook, and of course carry before it the pocket on the end of the strip of tape. The elasticity of the spring makes it curl round the thigh, and then, of course, the end of the tape can be seized and drawn downwards, and an efficient means of traction is thus secured. The author gives an account of twelve cases in which this means of delivery was used. As the chief objection commonly urged against it is the risk of injury to the fœtus, we quote the results from this point of view. Four times deep pressure-marks were found; twice superficial excoriations. In one case a fracture of the humerus was produced in drawing down the arm, and twice fracture of the femur—in one case made in an unsuccessful attempt to bring down a foot, in the other during extraction by the loop. No maternal bad result was noticed, except in one case rupture of the perineum during extraction of the shoulders.—*Med. Times and Gazette*, September 2nd, 1882.

CANADA

Medical and Surgical Journal.

MONTREAL, OCT., 1882.

SEMI-CENTENNIAL CELEBRATION OF McGILL MEDICAL FACULTY.

The Medical Faculty of McGill College has entered upon its 50th Session. Its opening day was a proud one for those who are to-day carrying on the good work so well begun now half a century ago. It had been decided to mark this event in a manner suitable to the occasion. Invitations were therefore issued to all medical graduates of McGill College, and to numerous representatives of other Universities both in Canada and the neighbouring States, to attend the opening lecture of the session, and to be present at a commemorative dinner in the Windsor Hotel. These invitations were accepted by a great number of guests, and both events have been entirely successful, and have afforded the liveliest satisfaction to all the friends of our University, as showing the love and enthusiastic esteem entertained by the old graduates for their Alma Mater. We may mention that graduates came from great distances, often at considerable personal inconvenience, to do honour to their College. From the West there were representatives from as far away as Chicago and Duluth; from the East, from Campbellton, New Brunswick, and from all intermediate points of Ontario and Quebec. From numerous graduates who were unable to attend came letters of regret conveying the kindest wishes and congratulations.

On the evening of the 4th October, the introductory lecture was delivered by Professor Howard, the newly-appointed Dean of the Medical Faculty, in presence of a large assemblage of graduates and undergraduates, and ladies and gentlemen spe-

cially invited for the occasion. The room chosen was the large lecture-room of the new Peter Redpath Museum. The address dealt with the history of the Faculty, starting from the foundation of the Medical Institution, and tracing the steps by which it had grown to its present strength and usefulness. An outline was given of each of the founders—Stephenson, Robertson, Holmes, and Caldwell. To them was added the name of Dr. G. W. Campbell, the late Dean, whose useful and exemplary life was drawn by a loving hand. Dr. Howard drew attention to the difficulties under which the Faculty labour for want of an Endowment Fund, a great many equipments being necessary to enable them to keep pace with the rapid progress of medical science. After the address, the charming rooms of the Museum were thrown open, and the remainder of the evening was spent by the guests with music and conversation.

On the evening of the 5th October, a dinner was given in the large dining-room of the Windsor Hotel. Two hundred guests sat down. Amongst the invited guests present were: His Honor Dr. Robitaille, Lieut.-Governor of the Province of Quebec, Principal Dawson, Dr. Joseph Workman of Toronto, Dr. Chadwick of Boston, President Buckham of Vermont, Dr. Grant of Ottawa, Dr. Hingston of Montreal, Mr. Andw. Robertson, President Montreal General Hospital, Dr. Rottot, Dr. F. W. Campbell, Mr. D. Morrice, Rev. Dr. Jenkins, Hon. Mr. Chauveau, Dr. Laramee, Mr. Alex. Campbell, Dr. Trudel, Hon. Dr. Church, Dr. Henry Howard, Prof. Prior, Q.C., Prof. Archibald, Prof. Harrington, Prof. Bovey, Mr. Duncan Robertson, Prof. Moyse, Dr. Wilkins, Mr. John Stirling, Mr. Manson, Mr. S. E. Dawson, Dr. Lamarche, Judge Torrance, Mr. John Molson, Rev. Dr. Murray, Mr. Hugh McLennan, Hon. D. A. Smith, Mr. J. H. R. Molson, Dr. Covernton, Prof. Johnson, and many others, representatives of the sister Universities, and friends of the College. The entertainment was everything that could be desired, and the greatest harmony and goodwill prevailed. The great event of the evening was the announcement by the chairman, Dean Howard, that, following upon his remarks of the day previous, he had received a note from a gentleman (whose name

he was not allowed to give) offering that if, before next August, a sum of $50,000 were subscribed to endow the Faculty, he would be ready to add to that an equal amount. This generous offer was received by all with manifestations of the greatest delight.

It is our intention to send to each of our subscribers a copy of Dr. Howard's address and a portrait of the late Dean, Dr. Campbell, together with the speeches at the dinner. We do not at present, therefore, give any more detailed account of these very interesting proceedings.

We congratulate the Faculty upon the success which has attended their efforts at securing a general gathering of their graduates to commemorate this important event, and upon the hearty response which they have met with from all quarters. Apart from the more public proceedings, much private enjoyment was experienced by the meeting of old College friends who had been separated for many years, and who might never have met except for the opportunity here afforded them. It was a pleasant sight to see these frequent meetings during the two days of the festivities, and interesting to watch two former chums, each trying to recognize in the greyish middle-aged man the rollicking student of his recollection; and then the stories and the memories of old times, the old scrapes both had been concerned in, the reminiscences of the old teachers,—all this was very pleasant.

And now McGill begins its second half century—hopeful and confident, not boastful—and we wish it all success and prosperity.

THE CANADA MEDICAL ASSOCIATION AND McGILL COLLEGE.

Our last number contained a full account of the recent successful meeting of this our Dominion Association at Toronto. This journal has always strongly advocated the necessity of maintaining this society in an efficient condition and rendering it thoroughly representative of medical progress throughout all sections of our country, and of the views of the profession generally in the Dominion. It has now held meetings in nearly every

city of any magnitude, and at these gatherings the proceedings have always been harmonious and conducted by all with a spirit of fairness and unanimity which has rendered attendance upon them a pleasure to all. It is, therefore, all the more surprising to find that one of the Toronto journals—the *Canada Lancet*—in its last issue uses expressions equivalent to saying that, up to the present time, the Association has been governed by those belonging to McGill College. It looks forward to a large increase in the membership when, says the *Lancet*, "it can no longer be said to be under the wing of McGill or any other College." This is the first intimation we have ever had that McGill College had taken the society "under its wing," and we are at a loss to conceive what could have led the *Lancet* to make such a atatement. We are happy to know that for several years past Montreal men, and those connected with McGill especially, have been diligent in their attendance, and have taken an active part in the proceedings. Those who wish well to the society would like to say the same thing of every city and every college in the Dominion. And is it because the men from McGill have thus performed what they consider a public duty that they should be subjected to remarks calculated to render them so misunderstood as actually to appear to desire to control the society in any way? Surely, this is not the way to encourage the profession generally to lend their active support to the keeping up of our common Association.

Near the close of the proceedings the next place of meeting had to be decided upon. Kingston was named by the nominating committee. A member from Montreal (and from McGill College) proposed Montreal. The result of a vote was the selection of the former by a considerable majority. There existed, however, according to the *Lancet*, "a feeling that the Association is being manipulated by McGill Professors and their friends," and that *therefore* the proposition to visit Montreal was negatived. We have it on the authority of the same article that the editor "has no sympathy whatever with" this feeling. We leave to any ingenious reader so inclined, the task of reconciling this with the previous remark concerning the rela-

tions between the society and this College. Now we should like to say that we think the *Lancet* has not been well informed when referring to the existence of such a feeling on the part of any considerable number of the members of the Canada Medical Association. That a certain few might feel so is, of course, possible, but at the same time if these would honestly consider the matter they could not but conclude to reverse their previously entertained opinion. That the motion was really defeated for this reason is not in accordance with the facts of the case. It is always competent for any member to move an amendment to a recommendation of the nominating committee, and Dr. Roddick did so in the exercise of his ordinary privileges as a member, and in the interests of what he thought best for the society. But, what completely proves what we wish to show, is the fact that all the other members present connected with McGill College voted *against* coming to Montreal and in favor of Kingston. Does that look like an organized attempt on the part of McGill College to control the action of the society and to influence its movements?

Anything like the introduction of sectional matters into the affairs of the Association is much to be deprecated. Let all work together for the common good on what should always be kept as neutral ground, then all will go well, and the society will prosper; but let sectional differences be introduced, and a good beginning will be made towards weakening the foundations and the structure will soon fall into ruins.

SEMI-ANNUAL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS, PROVINCE OF QUEBEC.

The semi-annual meeting of this College (the Provincial Medical Board) was held in the rooms of the Medical Faculty of Laval University, Quebec, on the 27th September, Dr. Robert Palmer Howard, of Montreal, President, in the chair. The following governors were present; Drs. C. E. Lemieux and E. H. Trudel, Vice-Presidents; Drs. A. G. Belleau and F. W. Campbell, Secretaries; Dr. E. P. Lachapelle, Treasurer; Dr.

Leonidas Larue, Registrar; Drs. Jas. Lanctot, L. D. Lafontaine, E. Gervais, J. B. Gibson, O. Bonin, Alf. Simard, Robert Craik, Thos. Larue, L. T. E. Rousseau, R. A. Kennedy, T. A. Rodger, Jos. Marmette, Chas. Gingras, E. A. De St. George, C. S. Parke, R. F. Rinfret, W. Marsden, Jules Prevost, F. X. Perrault, J. A. Sewell, N. H. Ladouceur, and the Hon. J. J. Ross.

After the reading and adoption of the May meeting minutes, the President moved, seconded by Dr. C. E. Lemieux, and unanimously resolved:—"That the Board of Governors of the College of Physicians and Surgeons of this Province have heard with much regret of the unexpected death of Dr. George W. Campbell, late Dean of the Medical Faculty of McGill University, and its Professor of Surgery for forty years, one of the original members of this College, for some time one of its Governors, and for about half a century a distinguished practitioner of the medical art; and desire to bear testimony to his talents as a teacher, his eminent abilities as a practitioner, his high character as a colleague, and his honorable career as a citizen."

The reports of the Assessors of Laval University at Quebec and Montreal were read and adopted, providing that the latter will give the names of the graduates to the Montreal Secretary.

The following gentlemen were admitted to the study of medicine:—J. H. Darey, Montreal; Louis V. Benoit, St. Hyacinthe; Alex. Kinloch, Montreal; H. Hervieux, St. Jerome; J. D. Fontaine, Belœil; L. S. P. Normand, Three Rivers; P. Ulric Garneau, St. André de Kamouraska; Alfred Mallette, Montreal; J. Legault, St. Valentine; A. St. Amour, Acton Vale; A. Laval, Yamaska; D. McNamara, Mile End, Montreal; G. B. Tanguay, Quebec.

Mr. Key's, of Georgeville, application for registration was refused on account of being an eclectic.

The following graduates received the license of the College on being sworn on their respective diplomas:—Drs. Arthur Hébert, of Quebec; Elz. Laberge, of St. Roch's, Quebec; Jos. Valere Côté, of St. Raphael de Bellechasse; G. A. Casgrain,

of St. Agapit: T. W. Mills, L.R.C.P., Lond.; Walter de Moulpied, Chas. O. Brown and Levi J. Lennox.

Moved by Dr. J. B. Gibson, seconded by Dr. T. A. Rodger, and unanimously resolved :—" That whereas certain rumours have prevailed whereby it is stated that private examinations are given by professors connected with a Medical School in this Province, and recognized by this College, and that on these examinations certificates are issued, purporting that the bearers are entitled to a diploma, and are in fact medical practitioners; and whereas one Emile de Lorimier, a student of this College, has publicly stated that he was so examined, and paid a large sum therefor, and holds such a certificate; and whereas, in the interests of the profession, it is the duty of this Board to ascertain if such irregular examinations are held by any school in this Province, or if certificates or diplomas are granted upon examinations other than those which take place before the Assessors appointed by this College;—be it therefore resolved that a committee be appointed to make investigation into these statements and report at the next meeting of this Board, and that the committee be composed of Drs. Craik, Hingston, Lachapelle, Robillard and Rodger.

The reports of the Treasurer and of the detective officer of the College and a new tariff were submitted.

North-Western Veterinary College.—The prospectus of the second session of this Institution has been received, and we congratulate Dr. Lyford, the Principal, and Faculty on the excellent arrangements which they have made. Following the example of the Montreal school, of which he is a graduate, Dr. Lyford has wisely insisted from the outset on a high standard, and requires each candidate for the diploma to pass an entrance examination and to spend three winter sessions and one summer session. The College is connected with the Minnesota Medical School, and doubtless the association will be mutually beneficial. Dr. Lyford is an alumnus of McGill University, and is well aware how satisfactory the arrangements are which have existed for many years between the Medical Faculty and the Montreal

Veterinary College. We are glad to see associated with him two other Montreal graduates—H. J. Burwash, M.D. (McGill, '79), and Richard Price, V.S. We sincerely wish the College every success.

Dean of McGill Medical Faculty.—Prof. R. P. Howard has been appointed Dean of the Medical Faculty, McGill University, in place of the late lamented Dr. Campbell. We offer the new Dean our sincere congratulations upon his promotion, and trust that the Faculty may more than ever flourish under his skilful management.

Medico-Chirurgical Society of Montreal.—At the annual meeting of this Society, held on the 6th inst., the following were elected officers for the ensuing year: *President*, Dr. R. A. Kennedy; *1st Vice-President*, Dr. T. G. Roddick; *2nd Vice-President*, Dr. T. A. Rodger; *Secretary*, Dr. Andw. Henderson; *Treasurer*, Dr. W. A. Molson; *Librarian*, Dr. D. F. Gurd; *Council*, Drs. F. W. Campbell, Osler and Geo. Ross.

Pharmaceutical Association.—The fifteenth session of the Montreal College of Pharmacy was opened on Tuesday evening, the 3rd inst., at the rooms of the Pharmaceutical Association, corner McGill and Notre Dame Streets. Mr. H. R. Gray delivered the opening lecture on "Pharmaceutical Education" to a very large audience. Dr. Reed, Mr. David Watson, Prof. Bemrose, Mr. Bennett of Philadelphia, and Mr. Ahern, also made a few remarks, after which a large number of students enrolled their names for the lectures, and the prospects are that all the classes will be well filled. Several names have been handed in, and it is probable that a class of practical pharmaceutical chemistry will soon be in operation under Professor Bemrose.

Druggists and Liquor Selling.—Several of our leading pharmacists were very much surprised, about three weeks ago, at being summoned to appear at the Police Court for selling spirits of wine. They were entirely ignorant that they had been violating any Act of Parliament. We cannot help thinking

that the action of the License Inspector was hasty and injudicious, as we are satisfied that whatever sins our Montreal pharmacists may have to answer for, liquor-selling is not one of them. However, "all's well that ends well," and the pharmacists are to be congratulated on the sensible view taken of the situation by the Hon. Mr. Wurtele, Provincial Treasurer, who, when the matter was explained to him, ordered the withdrawal of the actions already instituted. It is understood that the pharmacists can now sell spirits of wine for medicinal use in quantities of not more than an imperial pint. A special license will be issued, by an order in council, to those wishing to sell wholesale in quantities of not less than two imperial gallons.

Pessary on the Brain.—In a speech at the recent meeting of the British Medical Association, Prof. Playfair speaks of the "over much and injudicious local treatment" of the uterus. He alludes to a case in which "the patient may fairly be said to be suffering from pessary on the brain—so incessantly is she thinking of one or other of the *seventy-nine* different instruments which she has had inserted in the last few years in America and in this country."

The "Popular Science Monthly" for October, 1882.—This number is one of great excellence. It contains several papers which are of considerable interest to medical readers. The chief one is that by Dr. Douglas Graham, on "Massage: its mode of application and effects." Another, by Mr. W. Mathieu, is very suggestive. Its title is sufficiently odd. It is, "The Utility of Drunkenness." The author treats it from the standpoint of "survival of the fittest," inebriety furnishing a means, supposed to be agreeable to themselves, of clearing the world of the "unfittest." "Delusions of Doubt" is a description of a curious form of mental disease. Dr. Felix Oswald lends the unique charm of his keen humour to the discussion of "Physiognomic Curiostitics." The portrait and sketch are of Prof. Virchow, physiologist, anthropologist, and advocate of popular rights.

Personal.

Walter Moffatt. M.D. (McGill, '68) is at Pensacola, Fl.

W. K. Law, M.D. (McGill, '77) is practising at Coleraine, Ireland.

T. J. Pierce O'Brien, M.D. (McGill, '82), is at Kansas City, Mo.

R. F. Rooney, M.D. (McGill, '70) has moved from Colfax to Auburn, Placer Co., Cal.

Clarendon Rutherford, M.A., M.D. (McGill, '82) has begun practice in Chicago.

Wm. Young, M.D. (Bishop's, '78) has moved from Hong Kong (China) to Montreal.

Mr. Knowsley Thornton, the ovariotomist, passed through Montreal on the 5th.

Chas. M. Stevenson, M.D. (McGill, '—), has moved from Barnston, Q., to Coaticook, Q.

The many friends of Dr. Chadwick, of Boston, were rejoiced to see him at the McGill semi-centennial festival.

We were pleased to have a call from an old friend, Henry C. Fielde, M.D. (McGill, '77), of Barbadoes, who is on a visit to friends in Canada.

Thos. Kelly, M.D. (McGill, '73) has been appointed surgeon to the Colonial Hospital, Georgetown, Demerara, W.I.

W. D. Ross, M.D. (McGill, '75), whose address in the last McGill College announcement is given Buckingham, is in Pembina, Da.

Dr. Morrell McKenzie, of London, has been making a six weeks tour of the country. He was in town at the time of the A. A. A. S. meeting.

Dr. J. Collins Warren, of Harvard Medical School, was in town for a few days. He is the worthy representative of the Warren family which has furnished celebrated anatomists and surgeons to Harvard for a century.

It is curious that in the 100 years of the existence of Har-

vard School, only three men have filled the chair of anatomy—John Warren, John Collins Warren, and Oliver Wendell Holmes, the present occupant, who entered on his duties in 1847. *On dit* that this is his last session, and that he is prepared to resign.

Dr. Henry Harkin, lately of Guelph, Ont., has removed to Montreal, where he has commenced practice. Before leaving Guelph he was the recipient of a handsome testimonial from his many friends in that city, and an address expressive of their regret at having to part with him. We are most happy to welcome Dr. Harkin, as an old friend, to this city.

Medical Items.

—Chiari, of Vienna, has been called to the chair of Pathological Anatomy at Prague, as successor to Klebs.

—The class in the Medical Faculty, McGill College, is the largest for several years. Up to the 12th inst. there have been 58 new entries.

—Hæmophilia is said, by the *British Medical Journal*, to be the disorder from which H.R.H. Prince Leopold suffers from time to time. He is just now recovering from some attacks of hæmorrhage.

—A man was killed recently on the Canada & Atlantic Railway. The following was the verdict given: "That death was caused by hemorrhage from the *ephemeral* artery and its branches; said hemorrhage was caused by cars running over him."

—At the time of the plague in London, a noted body-searcher lived whose name was Snacks. His business increased so fast that, finding he could not compass it, he offered to any person who should join him in his burdened practice half the profits; thus those who joined him were said to go with Snacks. Hence going snacks, or dividing the spoil.—(*Morning Herald*, in London *Lancet*, Oct. 6th, 1823.)

—Of the 917 graduates in medicine of McGill University, 192 are known to be dead. Of those whose addresses are known, there are in Ontario, 237; in Quebec, 207; United States, 139;

Great Britain, 34; Manitoba, 25; New Brunswick, 9; Nova Scotia, 6; Prince Edward Island, 8; Newfoundland, 4; British Columbia, 4; India, 2; New Zealand, 3; West Indies, 6; Sandwich Islands, 1. The three oldest living graduates of the University are Roderick Macdonald ('34) of Cornwall, Joseph Workman ('35) of Toronto, and F. W. Hart ('35) of St. Martinville, La.

Dental Qualifications.—The *Louisville News*, in expressing surprise at the conviction of a dentist in Vienna for want of proper qualifications, thus epitomizes what is required of a tooth extractor in the United States: A hard grip and a strong arm; anything for instruments, from a shoemaker's nippers or a blacksmith's tongs to a monkey wrench; a diagnostic skill (not always possessed) sufficient to ensure the differentiation of the decayed tooth from a sound one standing next to it; and a total indifference to human agony.

Diagnosis of Uterine Disease by the Laryngoscope.—Dr. Seiler was consulted by a young girl with general relaxation of the mucous membrane of the throat, which he concluded to be due to uterine disease, for which he advised her to put herself under the treatment of her family physician, as local treatment of the throat would be of no use to her. Her reply was: "Doctor, if I had known that you could see all the way down, I would not have come to you."—*Maryland Med. Journal.*

"More Babies"?—Not long since a doctor was attending a case of labour. About the time the baby arrived, an older chick of two years had found its way into the sick room, and watched the operation of tying the cord and separating and handing over to the nurse with marked interest. Doctor supposed little chap was now busy with the nurse, and proceeded to remove the after birth, and just as this was about completed, the little gentleman peeped over the opposite bed-rail and piped out—*more babies, doctor?*

Embalming.—In a recent article dealing with the process of embalming, the *Lancet* remarks that the principal Italian professors of this art keep their special processes a secret, although the chief steps are well known. The process of embalming is

stated to consist of five steps. First, cold water is injected through the whole circulatory system until it issues quite clear; this may take as long as five hours. Alcohol is then injected for the purpose of abstracting all the water from the body; this is followed up by the injection of ether to dissolve out the fatty matter; this injection is carried on for several hours—in thin subjects for two, in very fat ones for even as long as ten hours. After this a strong solution of tannin is slowly injected, and time is allowed for its soaking into all the tissues; this takes from two to five hours. Lastly, the body is exposed for from two to five hours to a current of warm air, which is previously dried by passing it over heated choride of calcium. The body can then be preserved for any length of time without undergoing change, and is as hard as stone.—*Student's Journal.*

—To Dr. J. E. Janvrin, of New York City, has been allotted the task of writing the chapter on the "History and Statistics of Ovariotomy," in the "System of Gynæcology by American Authors," now in process of preparation. All who wish their cases published are requested to send to Dr. J., 191 Madison Avenue, N.Y., answers to the following question:—1. Name of operator? 2. Age of patient? 3. Nationality? 4. Married or single? 5. Aspiration or previous tapping? 6. Duration of growth? 7. Laparotomy or vaginal operation? 8. Condition of patient at time of operation? 9. Were antiseptic precautions used? 10. Was the spray used? 11. Long or short incision? 12. Adhesions or other complications? 13. Double or single ovariotomy? 14. Pathological feature of cyst? 15. Treatment of the pedicle? 16. With or without drainage? 17. Duration of operation? 18. Complicated or uncomplicated history after operation? 19. Antipyretics used, if any? 20. Result. Cause of death, if any? 21. Primary or secondary operation?

Consumption and Tuberculosis.—Dr. McArthur is a sanguine advocate of the Churchill method. His Syrup of the Hypophosphites is an excellent preparation, and though we do not concede all the virtues claimed for it as a remedy for consumption, yet we can testify to its value from actual trial.—*Prof. Henry Gibbons, M.D., Pacific Med. & Surg. Journal, San Francisco, Cal.*

CANADA

MEDICAL & SURGICAL JOURNAL

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Original Communications.

AN ACCOUNT OF THREE CASES OF SCIATICA AND ONE OF PAINFUL STUMP TREATED BY NERVE-STRETCHING.

By JAS. STEWART, M.D., L.R.C.P. & S., Edin.

(*Read before the Canada Medical Association, at Toronto, September*, 1882.)

J. S., joiner, aged 38, when first seen in February, 1881, complained of having suffered severely from a pain in the course of the left sciatic nerve for four years. For a period of six months prior to coming under observation, he suffered so much, especially when standing, that he was unable to do any work. He has a markedly neurotic family history. He has been much exposed, and it is to "cold" contracted in roofing buildings that he attributes his present troubles. He complains of great tenderness when pressure is made over the course of the sciatic in the upper part of the thigh. He has been treated by the hypodermic injection of morphia, by blisters, by the internal use of turpentine, etc. None of the above means having any permanent influence over the severity of the pain, it was decided to stretch the nerve. This operation was performed on the 19th of January, 1881, with antiseptic precautions. On removing the dressings eight days afterwards, the wound was found united throughout. The result in this case has been very satisfactory. The pain which formerly troubled with such severity that he was unable to work, seldom afflicts him now, and then only in a mild degree. He is able to attend his work without any inconvenience.

The second case was in a man aged 58, labourer, who, for over a year previous to coming under observation, was unable to work on account of a severe pain in the course of the left sciatic and anterior crural. It is five years since the pain first troubled him, and it has been steadily increasing in severity in spite of the use of various remedies. On the 4th of October last his left sciatic was stretched, with antiseptic precautions. The wound was found united on the tenth day after the operation. The result in this case is not so satisfactory as in the previous one. He still suffers, but nothing in comparison to his former trials. He is quite able to work.

The third case was that of a man aged 23, who, for two years, has been afflicted with a most severe and rebellious form of sciatica. The employment of the usual remedies recommended in these cases had little or no effect in even mitigating the severity of the paroxysms. The left sciatic was stretched on the 28th of March last. The operation was one of much more than usual difficulty, on account of the nerve dividing after its exit from the pelvis, and the close adhesion which one of the branches (the anterior one) had formed to the surrounding tissues. Both branches were stretched. The wound healed in two weeks. It is now nearly six months since the operation was performed in this case, and as he has remained free from pain during all this time, he may be considered cured.

The fourth case is where stretching was resorted to for the relief of a painful stump. The patient, a man 70 years of age, had his left leg amputated three inches below the knee-joint five years ago. He says he has never been free from pain in the stump since that time. He is often unable to sleep at night on account of its severity. Two weeks ago his left sciatic, which was of an unusual size, was stretched. For a few days following the operation he experienced no relief, but during the last week the pains have almost ceased. It remains to be seen whether the relief will be permanent or not.

It is to the great kindness of my friends Drs. Mackid of Lucknow and Gun of Durham that I had the privilege of seeing and operating on the third and fourth cases.

Nerve-stretching is now a well-recognized and very successful means of treating obstinate cases of neuralgia. Dr. Chandler of New Jersey has collected seventy cases of rebellious sciaticas treated in this way; 97 per cent. of these cases were either cured or relieved. It is an operation that is not altogether devoid of danger There are, at least, five fatal cases reported. In three of these, chloroform appears to have been the cause of the fatal issue. In one case I was fortunate enough to be able to take a tracing of the pulse while the nerve was being stretched. The immediate effect of the stretching was a reduction in the pulse rate from 80 to 40. This occurred within ten seconds. At the same time there was a slight fall in the blood-pressure, which was previously low, from the chloroform. It is well-known that the violent irritation of a sensory nerve can bring about stand-still of the heart. As chloroform has somewhat a similar action on the heart, it is not at all wonderful that when these two powerful factors are in operation that a fatal result has occurred. As ether has directly opposite action to chloroform on the heart, it should always be used in these operations. In two of the reported cases ether was used, and the difference in its cardiac action from chloroform was strikingly illustrated. The utmost pressure exerted in pulling the nerve while the patients were under ether could not reduce the pulse more than four beats in the minute, and even this trifling reduction was some ten seconds in being brought about. With chloroform, on the other hand, a reduction of 40 beats per minute was effected almost instantly. Further, ether does not reduce the blood-pressure, and in this lies its great safety.

A CASE OF HYDATIDS OF THE LUNG.

By D. F. SMITH, M.D., Walkerton, Ont.

Miss K., a rather dark, muddy-complexioned girl, æt. 20 years, came to my office on November 4th, 1881, to consult about a running sore on the back of her chest. It was situated within two inches of the spine, and opposite the 8th intercostal space of the left side. There was a good deal of flabby enlargement in the neighbourhood of this spot, and by probing, several sinuses

were found running upward and outward from the common outlet or sore. There was no other bulging upon the chest; she had no cough, pain, or shortness of breath; but she was weak, emaciated, and had a poor appetite; catamenia normal, and no alteration in the pupils or superficial veins of thorax; liver and kidneys healthy. She gave the following history:—

About two years previous, complained for the first time of ill-health, which developed from a pain in the side and situation above-mentioned, soon followed by slight shortness of breath and very little cough; in fact, she scarcely remembered having had a cough till I questioned her upon that point; no expectoration. These symptoms, which were so slight that they were never considered in connection with her trouble, were also accompanied by occasional chills, fever and sweating, and continued about six months, with considerable loss of flesh and reduced strength, when a tumour as large as the closed fist developed near the inferior angle of the scapula. It had been diagnosed and treated as fatty tumour, cold abscess, &c., on two or three occasions, but pus invariably escaped on applying the lancet. Nothing extraordinary had been noticed about the pus, but the opening never completely closed, while matter always reaccumulated and formed a fresh tumour in about the same locality. In this way three successive abscesses were formed and their contents discharged. The patient objected to my laying open the sinuses, as I advised, and went away with a tonic and a solution of iodine with which to syringe the channels leading from the sore. On the 30th of November the patient was no better, but had decided to let me proceed as I thought best. She was accordingly chloroformed and the sinuses laid open by an incision extending from the 6th to the 9th ribs, and two inches to the left of the spine. The probe could now be made to pass deeply through three small openings in the 6th, 7th and 8th intercostal spaces. Two transverse slits an inch and a half long, corresponding with the highest and lowest openings between the ribs, were then made (upon a director) to connect with the first incision, when a considerable quantity of dirty greyish-brown-looking pus escaped through the newly-made openings. The finger could now be easily passed

through either intercostal slit, by which the costal walls of the cavity were felt smooth, regular and unyielding. The finger came in contact with no resisting substance in any other direction, except slight aortic pulsation. By means of an injection (iodised) made through the upper opening, pus and a number of different sized small, smooth and slippery walled cysts were forced through the lower opening, till the uncoloured injection and exploration with the finger indicated that the cavity was well cleaned out. The cysts were all open when they escaped, and quite collapsed. There would be none larger than a large-sized marble if distended to their fullest extent. Some of the cysts still contained a small quantity of slimy, semi-transparent glairy fluid. During the subsequent treatment, an occasional sac of the same character came away with the process of syringing. No microscopic examination of the contents of the cavity was made. The after-treatment consisted in washing out the cavity every day with injections of tr. iodine and water, 1 to 4, and sometimes 1 to 2, with the internal administration of iron and quinine. Drainage tubes were employed all through the treatment. The case progressed well, and recovery was complete in two months.

I have only seen the case two or three times since, but noticed that, although fairly well nourished, she has a cachectic appearance, but no cough, pain, or shortness of breath. She is at present teaching school.

Hospital Reports.

MEDICAL AND SURGICAL CASES OCCURRING IN THE PRACTICE OF THE MONTREAL GENERAL HOSPITAL.

MEDICAL CASES UNDER CARE OF DR. ROSS.

No. 1.—*Intense Chorea from Fright—Fatal in Ten Days—Autopsy.*

Emma M—, a strong-looking young girl, 18 years old, was brought to the hospital on Oct. 17th.

The history, given by herself in an exaggerated and almost incoherent manner, and as afterwards learned from her friends, is as follows: Patient was tablemaid at an hotel in the

city, and when carrying a tray of dishes five days ago, she ran against two men fighting in a passage ; one of them brandished a knife at his opponent, which gave her a great fright, causing her to drop the dishes. She was threatened with severe punishment by the cook for breaking the dishes, which terrified her still more. She felt very nervous, could not sleep, and could scarcely keep herself quiet. On the following day she packed her trunk and started for her home in the country ; she met her father when part of the way home (at Cornwall). At this time her hands and arms were in constant motion, and her speech was also defective. Her father said she must return to Montreal, although she insisted on going home. Her father got her on board the boat, and as he has always been a very intemperate man, became very drunk, and threatened to punish the girl unless she kept quiet. This, of course, only increased her terror, and the movements of arms and legs became worse. In this condition she was brought to the hospital, five days after her first fright; but the choreic movements did not develop until some hours after the fright. She had always been healthy, never appeared nervous, and does not belong to a neurotic family ; never had rheumatism ; menses regular.

Her appearance on admission is very striking. Arms and legs in constant motion, jerking about in every direction. The muscles of the face also affected ; is constantly making grimaces. The articulation is defective, and patient talks a great deal. Understands everything perfectly, and answers questions rationally, but talks so rapidly that some words can scarcely be made out. Heart and other organs normal. Urine has been retained for twelve hours ; was catheterized, and urine found to be normal. As patient had not slept for four nights, she was given chloral hydrate gr. xv, and repeated in four hours. She slept soundly till morning after the second dose ; the movements ceasing during sleep, but on waking up were as excessive as before. Ordered arsenic (Fowler's solution) ♏ vii twice a day hypodermically. Bowels moved by a purgative. Protrudes the tongue when told, but jerks it back at once. Pulse 96 ; temperature 99°F.

Oct. 19th.—Was very restless all night. Took chloral gr. xx,

Liq. Opii Sed. ♏ x, and repeated in four hours, but slept none. Talked a great deal during the night. No improvement in patient's general condition.

Oct. 20th.—The muscular movements of the arms and face as excessive as before. Had large doses of chloral last night, but slept none. Skin is hot to-day; temperature 101°F.; pulse 104. Tongue dry and cracked. Chest organs healthy. Hypodermic injections discontinued, and to have Fowler's solution ♏ x three times a day after meals.

Oct. 21st.—Is as restless as ever. Insomnia still present. Took pot. bromide 5i, chloral hydrate gr. xxx, in two divided doses, without effect; complains of great thirst. Temperature 103°F.; pulse 120; no heart murmur. Ordered an ice cap to the head. Bromide and chloral to be repeated.

Oct. 22nd.—Patient is a little quieter this morning, but has slept none since the first night of admission. Is getting very weak; passed urine in the bed; does not take nourishment very well. 4 *p.m.*—Is quiet, but not sleeping; pulse 120; temperature 105°F.; does not answer when spoken to. 6.30 *p.m.*—Patient died, as if from exhaustion.

Autopsy—A few recent-looking, soft, warty vegetations on the auricular portion of the mitral valves. All other organs of the body perfectly healthy.

No. 2.—*Acute Suppurative Inflammation of the Hip—Pyæmia—Death—Autopsy.*

William M—, aged 29, an Irish emigrant, was admitted to the hospital on Oct. 17th, complaining of severe pain in the left hip and some pain in the left knee. He had been treated by a physician for acute rheumatism, and was sent into hospital as if suffering from that affection. Says it first began eight days before admission; was perfectly well before that date. Has only been in this country a few months, and during that time has been employed at the wharf. Has always been a perfectly healthy man. Never had gonorrhœa or rheumatism. Says just a short time before this began he was exposed to great heat and subsequent cold; this occurred several times, and

shortly afterwards he felt the left hip becoming stiff and painful. He felt pain in the groin and about the head of the thigh bone; says the pain grew worse, and a day or two afterwards the right knee became painful. He soon felt feverish and began to perspire. No history of any injury to the hip at any time, and the patient knows of no cause for the present illness, except the sudden cooling when heated.

When admitted he was suffering very intense pain in the left hip-joint, and the pain did not appear to be eased by any position he could be placed in. There was great tenderness in the groin, and also just above and behind the greater trochanter. Any manipulation whatever causes the most intense agony. The right knee is also painful, and slightly tender to pressure on both sides of the joint. The whole body bathed in perspiration. Heart and lungs normal. Urine contains no albumen. Tongue slightly coated. Bowels constipated. Pulse 100; temperature 102½°F. Was ordered a purgative for the bowels, and put upon salicin gr. xv every two hours, with hot fomentations of a solution of sodæ salicylate to be applied to the affected joints. This treatment was pushed energetically for four days. The pain appeared to leave the knee, but was not lessened in the hip, which continued as tender and painful as ever. The temperature ranged between 101° and 102½°F., and the pulse never was below 100.

Oct. 21st.—Patient passed a very bad night; was not delirious, but exceedingly restless the whole night. The morning temperature was 99°F, but the pain in the hip still severe; no pain in any other joints. Still perspires freely. About noon had a severe chill, lasting twenty minutes; following the chill was a sudden rise of temperature to 103°F.; pulse 108.

Oct. 22nd.—Condition to-day is no better. Had quinine sulph. gr. x after the chill yesterday. The temperature this morning was 101°F. Pain still very severe. Appears to be slight flattening of the left buttock. No redness of the skin around joint. Quinine repeated.

Oct. 23rd.—No improvement in symptoms. On examination to-day, the left buttock is considerably flattened, with obliteration of the gluteal fold on that side. Just behind the great trochanter

is felt indistinct fluctuation, deep-seated. Just in front of the trochanter is also a point which seems soft and boggy. On exploring with a needle, no collection of pus was found. Pulse 112; temperature 103°F.; no return of rigors.

Oct. 25th.—Has had no relief of pain, and temperature has kept high, 102°F.; pulse rapid, 116. No more chills, but is very restless, especially at night. Patient was given ether to-day, and on introducing an exploring needle just in front of the trochanter major, a collection of pus was found. It appeared deep-seated, and closely connected with the bone. Dr. Roddick then made a free incision over this spot, parallel with the shaft of the bone, with strict antiseptic precautions. A large sub-periosteal collection of pus was opened, and several ounces of bloody-purulent matter escaped. On introducing a probe, the bone felt quite bare of periosteum, but it was not clear whether the abscess communicated with the hip-joint. A large rubber drainage-tube was introduced, and the incision dressed antiseptically. The patient rallied from the ether, and felt comfortable. Was ordered stimulants and small doses of quinine.

Oct. 26th.—A few hours after the operation the patient passed three or four stools in bed within a short time. There was no fall in temperature, still keeping about 103°F., with a miserably weak pulse, 120. Diarrhœa was checked with lead and opium pill. Towards night patient became delirious, and continued so till morning, delirium low and muttering, and appears to be failing fast. The hip was dressed again to-day; the swelling had gone down, but a large quantity of discharge from the opening. There is considerable swelling of the right shoulder, red and painful. Slight swelling and redness on the upper part of the right foot. Ordered quinine sulph. gr. xx, 6 ozs. whiskey, hot lead and opium fomentations to foot and shoulder, and opium at night, if needed.

Oct. 27th.—Patient is evidently failing very fast. Appears very low this morning. Pulse feeble and rapid, 130; temperature 102½°F, Takes no notice of what is going on about him. Passes urine in bed. Is perspiring moderately. Considerable tympanitic distension of abdomen. Both shoulder and foot more

swollen than yesterday. No distinct fluctuation in either place. The hip dressed again to-day ; swelling gone down, discharges considerably. Towards evening became much weaker. Face assumed a bluish tinge. Respirations rapid and shallow, 30 per minute ; pulse small and compressible, 136. Died of exhaustion during the night.

Autopsy 36 hours after death.—A large sub-periosteal abscess near the great trochanter, communicating with the joint, the whole articular surface being bathed in pus. A collection of pus on the right shoulder, but not communicating with the joint. Another small abscess in the right foot. Organs all healthy.

No. 3.—*Typical Progressive Muscular Atrophy—Rapid Progress.*

Patrick C—, aged 52, a coachman, admitted October 9th, complaining of weakness of the left arm and leg ; also has severe neuralgic pains in the left side of the head and neck. Says he first noticed this loss of power in the arm four weeks ago. Was perfectly well before that time, and could manage his pair of horses with ease. The loss of power has been gradual. At the first he noticed that he could not carry or lift any heavy object with the left hand, and since that time he observed that the muscles of the left arm were wasting, and the power becoming less each day. Has also felt some weakness of the left leg, but not very marked. The pain in the head has not been continuous, but is very severe at times. Has always been a healthy man. Had an attack of rheumatism when young, but none subsequently. No history of any injury to the left arm or shoulder. No history of syphilis. Patient is a married man, and has several children living, and all healthy.

On examination, his appearance is that of a healthy man. Nothing peculiar about his gait. The left arm is observed to be much smaller than the right, the wasting involving the whole arm, from the shoulder to the fingers. Well-marked fibrillary tremor seen all over the arm and shoulder, and slightly below the scapula. The muscles of the arm feel soft and flabby ; the deltoid and all the flexor muscles very much

wasted. The pronators of the fore-arm and adductors of the thumb appear to be atrophied to a greater degree than the other muscles. Cannot grasp anything firmly with the hand, but says the fingers often become cramped, and he is obliged to use the other hand to open them. Sensation is not impaired, and electrical excitability is good. Measurement shows the left wrist a half inch smaller than the right; just below the elbow the difference is 1½ inch, and above the elbow joint, around the deltoid muscle, 1¼ inch. Feels no pain in the arm, but says it often feels numb and heavy. No tender points. There is no wasting of the left leg, but on examination, the muscular power is found to be decidedly reduced. No alteration in reflexes. Rectum and bladder act perfectly naturally. No change in sexual power. Chest and abdominal organs normal. Urine normal. Pulse 72; temperature 98°F.

While under observation in the hospital, he had severe pain in left side of the neck and head, often requiring morphia to get any rest. No special treatment was pursued beyond daily faradisation of the affected limb. No change was observed, and he was discharged at his own request.

SURGICAL CASES UNDER THE CARE OF DR. RODDICK.

CASE I.—*Mixed Chancre attached with Phagædena—Treatment by Hot Carbolized Baths—Secondary Symptoms.*

(Reported by Mr. B. W. BURLAND.)

George R—, brakesman, aged 21, was admitted Oct. 1881. He had always been healthy. Nine days after exposure, he noticed two small pimples on the prepuce, near the frænum. After cauterizing, these disappeared apparently, but a single sore appeared in their place, about the fourteenth day after connection. This at once began to spread rapidly, and the prepuce soon became swollen to such an extent that the sore could not be exposed.

On admission, the phymosis was found complete; the prepuce swollen, œdematous, and tender in one spot beneath. The day following, the prepuce was slit up, exposing a large, irregular, phagædenic sore, occupying the lower portion of the glans and

involving about one-third of that body and the meatus urinarius. The ulcer was thoroughly cauterized with strong nitric acid, and then dressed with warm water.

Oct. 5th.—Phagædenic action apparently arrested; is ordered fifteen grains of potassio-tartrate of iron thrice daily, and a lotion of the same of the strength of ten grains to the ounce of water; besides, is to sit for two hours, morning and evening, in a carbolized hip bath of the strength of about 1 to 200, and temperature of 90°Fahr.

Oct. 10th.—The treatment above described has been continued, and the general appearance of the ulcer has very much improved. The patient is most anxious that the baths should be continued, as he experiences great comfort from them in the way of allaying pain and preventing erections. To-day he remained in the water for seven hours, the same temperature being maintained as near as possible. He says he would like to remain all day in the bath, being so comfortable there, and free from pain. Two suspicious-looking spots near the edge of the ulcer were touched with the thermo-cauteré. The glands in both groins are found to be enlarged, but not tender. There is decided induration about the margin of the ulcer.

Oct. 20th.—The baths have been discontinued, as the sore is bathed with healthy pus and tending to heal. Black wash ordered.

During the fifth week after the appearance of the sore the patient complained of sore throat and slight fever, followed in a day or two by a roseolar rash, evidently syphilitic. For the iron mixture protoiodide of mercury pill in quarter grain doses was substituted. The disease subsequently ran a mild course, the throat symptoms being the most troublesome. As the phagædenic ulcer healed it became necessary to pass a bougie through the meatus each day in order to prevent undue contraction.

Remarks.—The above case is interesting from two points of view. In the first place, phagædena, in our experience, is rarely followed by secondary manifestations. It prefers to attack chancroids, and we doubt very much whether it ever attacks a pure infecting sore. It will, however, now and then, as in this

case, become engrafted on a mixed chancre. The second point of interest in the case has regard to the treatment of the phagædena by hot baths. Mr. Hutchinson, of the London Hospital, has long been a strong advocate of this method. He keeps the patient for eighteen and twenty hours continuously in the bath. We are not aware, however that he carbolizes the water, although we consider this most essential. The object is not only to soothe, but at the same time to wash away the contagious pus as rapidly as it forms, and if the sore can be made antiseptic at the same time, there is so much more gained.

CASE II.—*Vesico-Vaginal Fistula, considered incurable by ordinary measures, relieved by a novel operation.*

Elizabeth H., aged 47, was admitted Oct. 31st, 1881, complaining of inability to retain her urine, having suffered in this way more or less for many years. She states that about sixteen years ago she had a very severe and tedious labour, lasting over three days. She noticed soon after that the urine did not flow as before through the urethra, but came from the vagina, and that she could not retain it. Two months after confinement she went to Philadelphia, and was operated on three times, but she thinks the condition was rather aggravated than relieved. Some six years ago she came under Dr. Fenwick's care, and was operated upon by him for the closure of the fistula, but owing to the fact that nothing but cicatricial tissue could be obtained to fill the gap, the operation did not succeed.

Condition on Admission.—On opening the vulva a red tumour is seen, about as large as a small hen's egg, which in places is excoriated, and from around it the urine constantly trickles. When patient coughs the tumor becomes very much larger and more tense. With the finger, by gentle pressure, the tumour can be reduced within the vagina, and can be pushed through a large opening in its upper wall, through which gap two fingers can be readily passed. It is with difficulty retained *in situ*, and on withdrawing the retaining pressure it at once returns. The gap appears to be nearly circular, and is surrounded by firm cicatricial tissue. On passing the finger further up the vagina

you meet, first of all, a number of hard masses, which are phosphatic calculi; these are situated in the posterior cul-de-sac. The latter is of normal depth, but the anterior is quite obliterated. The uterus is found above the gap, and is fairly healthy. The meatus urinarius is absent; perineum is short and is spotted with excoriations, due to the irritation of urine.

The red tumour described is the mucous membrane of the posterior and upper wall of the bladder prolapsed through the fistula, resulting from destruction of a large portion of the anterior and lower wall of the bladder and roof of the vagina. The patient complains that when she stands or walks this tumour protrudes beyond the line of the vulva, and is then constantly irritated by her clothing, and made to bleed. The patient is most anxious that some operation shall be performed for the relief of her condition. It is not thought possible, on account of the presence of so much cicatricial tissue, to close the gap in the ordinary way; but with a view simply to covering in the raw mucous surface, the following operation is devised and carried out:—

Dec. 10*th.*—Patient being etherized, the labiamajora and intermediate portion were dissected upwards for a distance of about two inches, the orifice of the urethra being cut through and removed with the flap. A quadrilateral flap, longer on the upper than the lower border (about $2\frac{1}{2}$ by 3 inches), was dissected from the inner side of either thigh, taking skin and subcutaneous tissue and everything down to the deep fascia. These were made to meet in the middle line, where they were found to cover the vaginal orifice and the extroverted bladder without tension. The edges in the middle line were brought together by wire and cat-gut sutures applied on the under or skin surface, the cellular tissue above being held together by an uninterrupted cat-gut suture. The upper edges of the flap were secured in the same manner, and subsequently strengthened above by bringing down and attaching to them by wire the flap consisting of the labia above mentioned. The gaps on either thigh were approximated as nearly as possible by means of wire and hare-lip sutures. The parts were then ordered to be dressed

every three hours with lint saturated in warm carbolic lotion (1–80), the cavity being syringed out with the same. A piece of oiled silk was introduced from below, and passed up beneath the flap, to prevent the irritation of the urine. Patient was removed to bed, and placed on a circular rubber bed-pan distended with air, and in a semi-recumbent position.

No feverish symptoms supervened, while the flaps remained vigorous and became rapidly covered with healthy granulations. On the 16th January, 1882, we find the following note :—Flaps look remarkably healthy, while the wounds in the thigh from which they were taken have quite healed, leaving a simple linear scar. About a dozen skin-drafts were planted on the "bridge" to-day. There is no longer any bearing down feeling, and the prolapse of the mucous membrane is barely noticeable.

The patient was ordered up February 10th, and left the hospital soon after. She has been going about all summer with comparative comfort, and presented herself at the hospital for examination on October 20th. The bridge was found to be strong, and at the same time deep enough to cover thoroughly the prolapsed bladder. In fact, it has taken the place of the anterior wall of the bladder to some extent, so that when the patient is lying down she can retain as much as a wine-glassful or more of urine, and will eject it at pleasure, thus keeping the clothing dry.

Altogether, we look upon the result as most gratifying, and we are confirmed in this opinion by the expressions of relief which have fallen from the patient herself. We have been asked why we did not simply close the vagina at once? That was thought impracticable, both on account of the cicatricial tissue present, and because the bladder bulged out beyond the vulva, and by its pressure was sure to burst open the flaps.*

* We are indebted for much of the above report to Dr. McLean, one of the Assistant Surgeons of the General Hospital.

Reviews and Notices of Books.

Transactions of the American Otological Society.

15th Annual Meeting. Vol. 3; Part I.; pp. 74. A. Williams & Co., Boston. 1882.

The American Otological Society consists of more than fifty "Ear Specialists," and meets yearly, in midsummer, at one of the fashionable resorts. This year the meeting was at Lake George, where the beauty of the surrounding scenery and the "awful silence of nature" must have added zest to the otological discussions. Societies of specialists are annually increasing, and they all publish transactions. The present volume is so small a one to emanate from a society of specialists, who are usually so prolix, that we readily excuse its appearance. The poor general surgeon will soon be improved out of existence, and no part of the body will be left for him to try his skill on. The head has already been taken possession of by a triumvirate of specialists who devote themselves entirely to the eyes, ears and teeth (and all the territory immediately adjoining.) The abdomen is almost a lost province, the low countries having already been surrendered to the ever-conquering gynecologist. The backbone and lower extremities belong to the orthopœdic surgeons, some of whom are even claiming the penis, and practise circumcision as a necessary preliminary treatment to the cure of deformities. These surgeons would leave but little practice in the hands of the prophets Moses and Mahommed.

But we are wandering from our subject. In the volume under consideration are eight papers. The first, by Dr. Pomeroy, of New York, advocates the use of *soft india-rubber drainage tubes in chronic suppurative inflammation of the tympanum, with narrowing of the Meatus Externus.* He has had greater success with this mode of treatment than with any other. This paper excited considerable discussion, and each member had an equally valuable means for treating the same affection.

The next three papers treat of ear disease in connection with brain disease. (1.) Dr. Mathewson, of Brooklyn, read a case

of cerebellar abcess following otitis media; and Dr. C. S. Merrill, of Albany, a case of acute middle ear inflammation, with death on the fourth day from extension of the disease to the brain. (3.) Dr. Reid McKay, of Wilmington, read a paper on a case of *aural polypus, facial paralysis, mastoiditis, chronic meningitis and optic neuritis.* The patient could not, of course, recover from all these affections, but under small doses of calomel, given until ptyalism was produced, he got rid of the mastoiditis and meningitis.

Paper No. 5 is by Dr. E. E. Holt, of Portland, Me. It treats of boiler-makers' deafness and hearing in a noise. He says all boiler-makers are more or less deaf; the affection induced in the ears does not differ materially from catarrhal otitis media. Dr. Holt does not believe deaf people hear better in a noise if the same tone of voice is adopted in a noisy place as is used in a quiet one. They hear better in a noise because people speak louder.

Dr. Theobald, of Baltimore, gives a case of complete closure of the external auditory canals, following otorrhœa.

Dr. Knapp, of New York, next gives a short paper on *The Treatment of Aural Polypi.* He says that the experience he gained in treating polypi of the eye for many years guided him in handling aural polypi. His method is to cause the polypi to shrink by the application of alcohol, or to let them grow till they become pedunculated, and then remove them with a forceps or snare. Repeated cauterizations, he says, only stimulates their growth. The subject of this paper seems to have much the same effect in exciting discussion among otologists as gynecological subjects have when introduced into a meeting of general practitioners. No less than thirteen out of nineteen members present took part in the discussion, which occupies nine pages of the transactions. In fact, out of the seventy-four pages, only thirty-nine are taken up by papers.

The last paper is by Dr. Brandeis, of New York, on exhaustion *versus* inflation in the treatment of some of the diseases of the middle ear and membrana tympani. Most of the papers are very interesting, but not of the character to be sent out in the

form of transactions. They would have been much more suitable for insertion in medical journals, but then, of course, the record of the discussions would have been lost, and the object of the meeting to some extent impaired.

Syphilis.—By V. Cornil, Professor Faculty of Medicine, Paris. Translated, with notes and additions, by J. Henry C. Simes, M.D., Demonstrator of Pathological Histology, University of Pennsylvania, and J. William White, M.D., Lecturer on Venereal Diseases, University of Pennsylvania.

Already we have several excellent works on venereal diseases, but this is perhaps the first attempt made by any author to treat of syphilis independently of other diseases of the genital organs. Professor Cornil's position as one of the medical staff of the Lourcine Hospital of Paris, has enabled him to collect a vast amount of original material. The book was first published in the form of "Leçons," but the translators, for the sake of uniformity, have changed the form of lectures into that of chapters, and have besides materially enhanced the value of the work by interspersing here and there clinical illustrations of subjects under discussion.

Professor Cornil appears to have studied the subject of syphilis from a purely anatomical and histological standpoint more thoroughly than perhaps any living authority. Thus, his microscopical observations have almost invariably been made upon tissues removed during life, or before they had time to undergo the slightest cadaveric change. His study of the various syphilitic lesions has been most accurate and complete. The important question of excision of chancre as a method of averting syphilis is fully and fairly discussed, although the author is himself inclined to be non-committal in his opinion. He thinks that while the results of the operation give support to the theory that syphilis is not at once generalized in the system before any apparent manifestations, still he cannot in the present state of knowledge regard it as proved. Visceral syphilis and syphilis of the nervous system are both discussed at considerable length. The

translators have added some very interesting notes on syphilis as a cause of locomotor ataxia. They conclude their remarks on this important question by saying "that although not quite prepared to accept the positive opinion of Dowes that locomotor ataxy is, with few exceptions, due to syphilis, we may unhesitatingly, in the light of our present knowledge, coincide with Erb in believing that the results of investigation justify us in concluding that there must be some not very indefinite etiological connection between syphilis and locomotor ataxia." In the chapter on treatment a number of excellent rules are given for the administration of anti-syphilitic remedies. Altogether the work is a valuable contribution to the literature of the subject, and will be found useful to the general practitioner as well as student of medicine.

Essentials of Vaccination: a compilation of facts relating to Vaccine Inoculation and its influence in the prevention of Smallpox.—By W. A. Hardaway, M.D., Professor of Diseases of the Skin in the Post-graduate Faculty of the Missouri Medical College, St. Louis, &c. Chicago: Jansen, McClurg & Co.

Many things connected with the subject of vaccination are not generally known, and about others the knowledge of a great many is of a very hazy description. Nevertheless, these things are often of much, and sometimes of vital, importance. This little monograph furnishes concisely an account of what it is essential to understand about the theory and practice of effectual vaccination. Starting with a short description of the original discovery of Jenner, the facts are given about the normal course of the artificial disease, Vaccinia, in man. A very good chapter is devoted to the abnormal modifications and complications which may be witnessed in a vaccinated person. The author is a firm believer in re-vaccination. He impresses upon us the necessity for a repetition of the operation after puberty, but would go further, and recommends its performance at intervals of five years, and, if the person be exposed to known infection, would even recommend its renewal after a few months. He inquires

into the kinds of vaccine virus and the methods of obtaining them, and discusses the various considerations connected with the operation itself; and finally disposes of the arguments of the anti-vaccinators by an irrefutable array of figures and a convincing logic. It is a useful and seasonable little book, and contains many things not easily turned to by the general reader, and being eminently practical and thoroughly sound, will no doubt find many appreciative readers.

Journal of Cutaneous and Venereal Diseases.—Edited by Henry G. Piffard, A·M., M.D., and Prince A. Morrow, A.B., M.D. New York: William Wood & Co.

We have been favored with the first number of this, the last-born of our already overstocked family, but we see in it evidences of a more than ordinary amount of vitality, and we hail its birth with pleasure. Besides, the well-known ability and energy of the editors is a sufficient guarantee of its success. The number before us is very neatly got up, and, besides a wood-cut or two, has a very beautiful coloured drawing of a case of Trichophytosis Cruris (*eczema marginatum*) which recently occurred in the the practise of Dr. Fox, of New York. The journal is to be issued monthly, at the very moderate figure of $2.50 a year.

The Diseases of the Rectum, including Fistula, Hæmorrhoids, Painful Ulcer, Stricture, Prolapsus, &c., with Diagnosis and Treatment.—By Wm. Allingham, M.D., F.R.C.S., surgeon to St. Mark's Hospital for Fistula and other Diseases of the Rectum, &c. Fourth revised and enlarged edition. With illustrations. Philadelphia: P. Blakiston, Son & Co.

This certainly is the day for cheap literature, and the medical profession is beginning to get the benefit of the keen competition amongst various publishing houses. The above standard work, one of a series, is now to be had in a neat paper cover for the sum of 75 cents. One could hardly expect to pay less than that. The book is too well known to require any special comment. It is, in fact, well recognized as one of the most complete monographs

on the subject in the English language. It is only necessary, therefore, to draw attention to the issue of an edition so cheap as to place it within reach of every one. Every practitioner knows the importance of these, often troublesome, rectal affections, and he should not fail, therefore, to have in his possession the best literature obtainable upon these special complaints.

Nitro-Glycerine as a Remedy in Angina Pectoris.—By Wm. Murrell, M.D., M.R.C.P., Lecturer on Materia Medica and Therapeutics at the Westminster Hospital; Senior Assist. Physician to the Royal Hospital for Diseases of the Chest. Detroit: George S. Davis.

The considerable degree of success which has been obtained by the employment of nitro-glycerine as a remedy renders it advisable for every one to have some knowledge of the properties and mode of administration of this powerful medicine. That it possesses a very decided influence over that dreadful disease, angina pectoris, is now attested by numerous cases. Dr. Murrell was one of the first to direct attention to its therapeutical properties, and he has conducted many experiments and observations with the view of elucidating these still further. In this little treatise he conveys very clearly the results he has arrived at. The cases suitable for its use, complicated and simple, the dose, and the best methods of administration, are all laid down in full, and, what makes it much more interesting, detailed reports of twelve cases of angina pectoris so treated are given. The conclusions of Dr. Murrell must be accepted as authoritative, considering the great attention he has for a long time given to the subject, and every physician should have the book by him as a useful guide to aid him in gaining with safety the assistance of a very valuable drug with which to oppose one of the most painful of all known diseases.

Books and Pamphlets Received.

A System of Human Anatomy, including its Medical and Surgical Relations. By Harrison Allen, M.D., Professor of Physiology in the University of Pennsylvania. Illustrated with three hundred and eighty figures on one hundred and nine plates, many of which are beautifully colored.

The drawings by Hermann Faber, from dissections by the author. Also, upwards of two hundred and fifty wood-cuts in the text. Section I.—Histology, by E. O. Shakespeare, M.D., Ophthalmologist to the Philadelphia Hospital. Section II.—Bones and Joints. Philadelphia : Henry C. Lea's Son & Co.

Index-Catalogue of the Library of the Surgeon-General's Office, United States Army.—Authors and Subjects. Vol. III. Chal-Dzon. With a list of titles of periodicals indexed. Washington : Government Printing Office.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, Sept. 22nd, 1882.

George Ross, M.D., President, in the Chair.

Pathological Specimens.—Dr. Shepherd exhibited a specimen of ossification of the sacro-iliac synchondrosis. On separation of the bones, the articular surfaces appeared quite healthy, but those of the lumbo-sacral articulations were somewhat diseased. This condition is sometimes found to be congenital, but in the case under notice Dr. Shepherd thought it was of rheumatic origin.

Subject of Paper.—Dr. Alloway narrated the following case : The patient, a woman, aged 24, was attended by himself and Dr. Rodger in her confinement. She had been in labour about 12 hours. Occipito-posterior position. Ether was administered, and Simpson's long forceps applied. During traction the head suddenly slipped from under the pubic arch and carried away the perineal body, sphincter ani and the recto-vaginal septum for fully two and a half inches in its extent upwards (length of index finger.) The immediate operation was done, which was a combination of Simon's and Emmet's. The rent in the bowel was first united by interrupted sutures of strong grey thread, the only material obtainable at the time. The perineum was united in the ordinary way, care being taken that the lower or Emmet's suture was entered low down on a level with the lower margin of the anus, on the left side, passing upwards and inwards over to the opposite side, and downwards to a point corresponding to its entrance on the left side. The vagina was well washed

out with carbolized warm water, the parts anointed with vaseline, and the patient's knees tied together. The carbolized injections were continued every two hours by a very faithful nurse in attendance. On the fourth day diarrhœa set in, which could not be arrested until several days had elapsed, it being due to the milk the patient was taking. The fluid faeces passed between the sutures into the vagina. Patient became very despondent, thinking she was ruined for life. On the 10th day carbolized injections reduced to twice only. On the 15th day removed all the perineal sutures, except Emmet's. This was left until the 18th day, when it and all the internal sutures were removed through the bowel. There was still a small fistulous opening in front of the sphincter. This, however, had completely closed by the 22nd day. From this out the patient made a perfect recovery. Was examined some months afterwards, and exhibited no laceration of the cervix, unless it had completely healed, and had a perfect perineum. Uterus normal depth. Dr. Alloway drew attention to the fortunate accident of diarrhœa having set in shortly after the operation, and alluded to a paper just then published in the *New York Medical Record* (July) by Dr. H. T. Hank, of the Women's Hospital, New York, upon the advisability of intentionally keeping the bowels loose during the whole period of treatment, from the second day after operation. Dr. Alloway attributed much of the successful issue to this circumstance.

Discussion on Paper.—Dr. Kennedy spoke of the great frequency of laceration of the perineum, especially in occipito-posterior positions of the head, in spite of the most skilful precautions on the part of the accoucheur. In such cases he favoured the method recommended by Dr. White, of Buffalo, of making lateral incisions on both sides as soon as the perineum becomes distended, thus preventing laceration through the perineal body, which is always more slow to heal. His experience was limited to laceration through the sphincter, which he always treats by immediate operation, and with success in the majority of cases. He mentioned having seen one case in which the septum was destroyed, and the patient had recovered to her own perfect

satisfaction, without operation. No opportunity offered for a subsequent examination in this case. He favoured keeping the bowels loose during convalescence, and was inclined to ascribe much of the good result in Dr. Alloway's case to this condition. In conclusion, he asked why ether was used in preference to chloroform. He personally favoured the use of chloroform, as the voluntary muscles are more relaxed by its use, and lying-in women appeared to enjoy immunity from its poisonous action. If pushed to its full action it tends to favour flooding, but he thought this action was due more to its lessening reflex irritability than from any other cause.

In reply, Dr. Alloway said he invariably uses ether, feeling much safer with it, and has never met with that relaxation of the uterus which he has frequently noticed after using chloroform.

Dr. Cameron also favoured immediate operation in these cases, as the difficulties are increased the longer it is put off; he thought sutures of silver wire were preferable to those of silk in the rectal tear, and these were easily applied by means of Pean's needles.

Dr. Roddick thought sutures of catgut were specially advisable in the rectal tear, as they required no further attention; he also recommended the use of intermediate sutures of catgut in the perineum as being preferable to all wire. Accidents with chloroform are rare in midwifery practice owing to the minor degree of anæsthesia induced, and the eagerness with which it is taken as a rule, whereas in general surgery the patients frequently resist, and thus, possibly, the danger is increased.

Dr. Ross complimented the reader of the paper on the readiness with which he had made use of the means at his disposal in the emergency, but thought he was singular in the use of ether in preference to chloroform, and that he had shown no special reason why the latter should not be used. The fact that flooding had followed its use was merely a *post hoc* argument, and it might also occur with ether; at the same time, he recognized the great danger of using chloroform in ordinary surgical practice. The great inflammability of ether, its bulk, and the offensiveness of its odour, all argue strongly against its use in midwifery practice.

Drs. Macdonnell and Mills also took part in the discussion, after which the meeting adjourned.

Stated Meeting, October 6th, 1882.

GEORGE ROSS, M.D., PRESIDENT, IN THE CHAIR.

This being the first meeting in October, was also the annual meeting.

President's Address.—The President, in delivering his address, gave a short *resumé* of the work of the Society during the past year, but, before proceeding to do so, made allusion to the removal by death of Dr. George W. Campbell, one of the Society's oldest and most respected members. He had always taken an active interest in the work of the Society, until failing health compelled him, unwillingly however, to absent himself from its meetings. The Society has had to mourn his loss, but by his example should be stimulated to further exertion in its work. The question of public health was next referred to. During the past year a draft of a bill was prepared by the City Health Officer and the advising attorney for the purpose of seeking for the incorporation of a complete system of supervision of public health ; this was submitted to a joint committee from the Board of Health and from the Medical Societies. This bill has not yet become law, but there is a prospect of its soon passing the Legislature. In August last the city was honoured by the presence of the members of the American Association for the Advancement of Science, among whom were many medical men from the United States and Europe. The meetings have been regularly held, the attendance has always been good, and the amount of work done has been very satisfactory. A number of interesting papers have been read by members, the topics of which have been extremely varied, and in most instances have given rise to animated and profitable discussions. The pathological specimens and anatomical preparations exhibited during the year have also been both numerous and interesting.

At this stage of the proceedings, Dr. Osler announced that Dr. Workman of Toronto, who had been on a recent visit to this city, was about leaving, and before allowing him to do so, thought

the Society should in some way express to him its sense of his many excellent qualities and its high appreciation of the services rendered by him to the medical profession. He then moved the following resolution, seconded by Dr. F. W. Campbell :—" *Resolved*,—That the members of the Medico-Chirurgical Society of Montreal, in session this evening, cannot allow the opportunity to pass of expressing to you the pleasure your visit to this city has been to them. They feel that to you the medical societies of Canada owe much, your zeal and ability having always been liberally expended in promoting their welfare ; and desire to express the hope that you may still be spared for many years to give them the benefit of your wisdom and counsel."

Subject of Paper.—Dr. F. W. Campbell then read to the Society the paper by Dr. A. H. David (who from severe illness was prevented from being present), entitled " Reminiscences connected with the Medical History of Montreal during the last fifty years." Dr. David's paper commenced with a reference to the establishment of the Montreal General Hospital and the Montreal Medical Institute, the former of which was opened for the reception of patients in 1822, with the following staff of attending physicians : Drs. Loedel, Lyons, Robertson, Caldwell, Stephenson and Holmes, all of whom were also associated in the formation of the Medical Institute, the first prospectus of which was issued on the 4th February, 1823, and which in the year 1829 became the Medical Faculty of McGill College. Of the thirty students who graduated in the following session, but five are still living—Drs. Roderick Macdonald, of Cornwall ; Joseph Workman, of Toronto ; Hamilton D. Jessup, of Prescott ; Frederick W. Hart, in Louisiana, U.S, and the writer of the paper. Dr. David then proceeded to give short biographical sketches of some of the gentlemen connected with these two institutions from their commencement down to more recent times. The formation of the Medico-Chirurgical Society in 1845 was then referred to, and the establishment of the medical press in 1845 by the issuing of the *Montreal Medical Gazette*, by Drs. Badgley and Sutherland, and which was the first entirely English medical journal ever published in this country. Sub-

sequently, in 1851, the *Canada Medical Journal* was started by Drs. R. L. Macdonnell and David, and in 1854 the *Medical Chronicle*, by Drs. Wright and McCallum. All of these journals had but an ephemeral existence, actually dying from inanition. In 1865 the *Canada Medical Journal* was revived by Drs. G. E. Fenwick and F. W. Campbell, and was carried on successfully for twelve years, when it merged into two separate journals, the *Canada Medical Record* and the *Canada Medical and Surgical Journal*, both of which still exist in a prosperous condition. Reference was then made to some of the changes in the practice of medicine and surgery which the writer had seen during the last fifty years, chief among which was the introduction of anæsthetics, the hypodermic syringe, bloodless operations, and antiseptics. By the operation of ovariotomy alone, it is said, 40,000 years of life have been gained for women. Excision of the kidney or spleen, part of a cancerous bladder, or prostate, of the rectum, and of the pylorus, are now common, and attended with improving results. In concluding, Dr. David said, "The world has always been full of, and is still full of, hypotheses and speculation—full of new remedies, new instruments, and new appliances. Once in about every decade of years old things pass away, but amid all the revolutions going on in the intellectual, moral and scientific world, there is great comfort in the reflection that principles never change—they are immutable and eternal."

Extracts from British and Foreign Journals.

Unless otherwise stated the translations are made specially for this Journal.

An Artificial Membrana Tympani made of Elastic Collodion.—Mr. Toynbee, of London, was the first who made an artificial membrana tympani. It was a thin india-rubber disk with a wire stem, to facilitate its introduction. It was at best a mere shield to the tympanic cavity, preventing the ingress of foreign bodies, but of no value to audation. Discs of paper were substituted, but with no better result. Of late small pellets of cotton, moistened with glycerine, were introduced, with marked improvement of hearing. But the greatest result in that line was achieved by the elastic collodion,

both as a protective to the middle ear, and as a conductor of sound, as the history of the following case will abundantly illustrate :—

A young lady, aged twenty, came to my clinic, suffering from a profuse fetid discharge from her right ear, with total absence of hearing from her fourth year. After cleansing the ear with water, the membrana tympani was found entirely wanting. Not a trace of the ossicles was seen, and the tympanic cavity was filled with a granulating mass, almost of polypoid growth, which bled at the most delicate touch. The auditory canal and the mastoid process were in a normal condition. I poured warm alcohol into the ear, which had the effect of shrinking up the granulations quickly. The use of alcohol for polypoid growths is now generally adopted, and, in my hands, has always proved satisfactory. These granulations were easily wiped out with a little cotton attached to the probe, and the cavity of the tympanum was plainly exposed. As stated, not a trace of the ossicles nor the tympanic membrane was seen, but the foramen avale and rotundum, with their membranes, were in clear view. There was no necrosis or mere roughness of the promontory or any other part of the cavity. Hearing distance of the watch, on the meatus, 0, the same on the process, the bone conduction of the vertex good, a proof that her deafness was not labyrinthine.

After treating the purulent otorrhœa for a few days, it occurred to me to try to improve her hearing by means of an artificial membrana tympani. I made a suitable pellet of absorbent cotton, moistened with glycerine, and adapted it carefully to the cavity. It improved her hearing about one inch. I left it in two days. Just about that time I read in the "Transactions of the International Medical Congress," in London, 1881, a report made by Dr. Krause, of Hamburg, Germany, about the use of elastic collodion in making an artificial membrana tympani. The idea struck me as being good and eminently practical, and I determined to try it at once with this patient. I followed strictly Dr. Krause's formula.

The patient having been placed in an absolutely horizontal position, I instilled first a few drops of a solution of tannic acid

in glycerine—2 gr. to 5i—which, being an astringent, was presumed would act beneficially on the suppurative inflammation; a few drops of elastic collodion were instilled upon that, and suffered to remain undisturbed until it solidified. In ten minutes I found that the collodion was unevenly spread. Thicker inferiorly and very thin above, so that it gave way in the upper part and the glycerine oozed out. Most likely the level was not true, and the fluids, probably too large in quantity, gravitated downwards. So I took it all out, dried the ear carefully, and renewed my experiment. I was intent to have the level absolutely correct. I instilled only three drops of the solution of tannin in glycerine, and on the top of it three drops of collodion. In a few minutes solidification was effected; a beautiful membrana tympani, almost resembling a natural one, presented itself to my view, of equal colour and probably of equal thickness. It was solid and strong, vibrating on inflation by the Valsalva method. The test with the watch proved that she could hear it seventeen inches. The joy of the patient was only equal to my surprise and satisfaction, as well as to the pleasure of the numerous students and medical gentlemen. This was on Saturday. On the next clinic day—Tuesday—the artificial membrane was yet intact and hearing distance greater. But on account of the long existence of the purulent otorrhœa, I deemed it best to rupture the membrane, in order to enable me to cleanse the ear, and desepticise it. This was easily accomplished. A mere touch with the probe perforated it, let out the tannic solution and also some fetid pus. The same process was gone through as before, and a new membrana tympani formed in ten minutes, and with each renewal hearing improved, so that now hearing is normal—that is, my watch is heard forty-eight inches.

Please follow me in the different steps of the experiment.

1. The quantity of tannin and collodion must not exceed three drops each. A large quantity of tannin is too heavy and too bulky for a thin film of collodion to resist; a larger quantity of collodion will not spread evenly, solidifies slowly, and will be too thick for vibration.

2. The interposition of a fluid between the artificial mem-

brana tympani and the drum is indispensable in order to enable the membrana tympani to vibrate. I have tried once to instil the elastic collodion directly into the cavity. It solidified quickly, it adapted itself accurately to the uneven surface of the cavity, but there was no hearing whatsoever. It was no easy matter to remove the collodion then. I had to dissolve it by pressing against it absorbent cotton dipped in sulphuric ether, and gradually wipe it out. As soon as I returned to the first instilling of glycerine and tannin, hearing was at once restored.

3. The head must be on a perfect level while solidification is going on; any deviation from it will make the artificial membrane of unequal thickness, rupture easily and vibrate badly.

The *rationale* of this extraordinary result appears to me to be that the labyrinthic part of the ear is perfectly healthy; that the total absence of the drum head and ossicles are the chief cause of her complete deafness (caused probably by the otorrhœa purulenta); the artificial membrane is a fair substitute for the natural one, and the interposing fluid assumes, in part, the functions of the ossicles. Instead of the membrane in the foramen ovale being driven in by the foot of the staples, it is somewhat impressed by the fluid, which is set in motion by the sound wave, and which displaces the otolymph and thus impinges upon the membrana Corti or the acoustic nerve.

This lady patient of mine is very intelligent and very amiable, and if desired, she would present herself, properly escorted, before the society; I could then demonstrate, to the satisfaction of all, the really marvellous results of this new appliance in aural surgery,—Dr. S. Pollak, in *St. Louis Medical and Surgical Journal.*

Cazin on the Diagnosis of Hip-Disease by Rectal Examination.—Dr. H. Cazin (*Rev. de Chir.*, March, 1882,) refers to the difficulty of diagnosing the exact seat of the disease, especially with regard to the acetabulum. This difficulty is of much importance when the question of resection has to be considered, and is one of the strongest points of argument advanced by the opponents of resection. The author made researches in 98 cases of hip-joint disease, 64

being suppurative and 34 non-suppurative. Hitherto only incomplete evidence has been obtained by depending upon the seat of the pain, the seat of abscesses and fistulæ, and by exploration with the sound. Abdominal palpation enables us to detect enlarged iliac glands or pelvic abscesses; but if we also examine the patient through the rectum, the diagnosis will be much more sure. The hip-joint, from its deep position in the tissues, is not very accessible to ordinary methods of examination, but the finger can approach it most easily through the rectum. In the cavity of the pelvis, immediately above and a little behind the obturator foramen, is a quadrilateral surface of the bone, corresponding with the bottom of the acetabulum. In a child under 14 years, this part of the pelvis is partly cartilaginous. The Y-shaped cartilage is so situated that the area of the base of the acetabulum is divided by a transverse line of cartilage into two equal parts, and the lower half is again divided by the horizontal line of cartilage. In examining a patient, the natural extent of the cartilage should be considered, and the two sides should be explored for the sake of comparison. This mode of examination has afforded appreciable results in 49 of the 98 cases which Dr. Cazin has had under observation. Of the 64 cases of suppurative hip-joint disease, positive results were obtained in 37. Of the 34 non-suppurative cases, in 12 only was the examination *per rectum* diagnostic. The ages of the patients were between 3 and 18 years, and the majority were between 8 and 10 years; 41 were boys and 23 girls. Examination *per rectum* disclosed an alteration in the pelvis in 36 of the cases. Sex has no importance with regard to the facility of examination. Among the elder girls, the presence of the uterus has caused very slight trouble, and the position "on the knees" has facilitated the examination. In young adult females, recourse should be had at the same time, or exclusively, to examination *per vaginam*. The results of Dr. Cazin's examinations have been verified six times by resection, four times by necropsy, and twice by resection and necropsy combined. The symptoms elucidated by a rectal examination have been pain localized to the postcotyloid surface, produced by pressure; enlargement of the intra-pelvic

glands ; thickening of the bone ; depression, flexibility, mobility, destruction, or perforation of the postcotyloidean surface ; congestion of the soft parts ; and pelvic abscess. Pain upon pressure is the least certain of these symptoms. If the bone be penetrated, and the head of the femur be felt by the finger, a doubt in diagnosis may be removed if upon movement of the thigh the head of the femur is felt by the finger (*per rectum*) to move. Many cases are recorded. One was the case of a girl, 13 years old, in whom there were some symptoms of hip-joint disease, but it was thought by one of Dr. Cazin's colleagues that contraction of the muscles was the only affection. Under chloroform the deformity disappeared, and the joint became freely movable ; and it was only by a rectal examination, which disclosed a postcotyloidean swelling, that Dr. Cazin was convinced that particular disease existed. In conclusion, Dr. Cazin urges the adoption of this means of diagnosis, in addition to other methods, especially in reference to the subject of excision of the joint. He also maintains that *redressement force* should never be attempted until an examination *per rectum* has been made. The only other surgeons who, Dr. Cazin states, have referred to this method of diagnosis in hip-joint disease are Mr. Holmes, in his work on "Surgical Diseases of Childhood," and MM. Mathieu and Strauss, who have quoted Mr. Barwell.—*Lond. Med. Rec. ; Med. Gazette.*

Opposition to Koch's Theories as to the Bacillus Tuberculosis.—Before a largely attended meeting of the Philadelphia County Medical Society, held on Wednesday, Oct. 18th, Dr. H. F. Formad made a demonstration of the babilli tuberculosis, and made some remarks in which he claimed that so far there had been no reliable demonstration of the etiological relation of these bacilli to phthisis. He did not dogmatically deny it, but did assert positively that it could by no means be considered as proved. He objected to the importance attached to the reaction of those bacilli to certain staining fluids, because from his own experiments he had found it not to be peculiar. The result of Koch's inoculation experiments he discredited, because the successful ones had been made only on animals that have a very strong predisposition to tuberculosis,

and contract it from inoculation of non-specific substances ; while others claimed to be successful, he regarded as cases of pseudo-tuberculosis. The view in regard to the bacilli tuberculosis to which Dr. Formad inclined was that they do not cause the disease, while it is likely that they do "condition the fatal issue."

The remarks, which will be published in full hereafter, were received with marked interest, and were followed by a brief discussion, participated in by Drs. Wood, Gross, Tyson, Bartholow, Cohen and others. None of the speakers seemed to have adopted Koch's views, and it was spoken of as a matter for congratulation that one so well fitted as the first speaker should have presented the arguments against them ; since the truth would be arrived at the more surely if the new doctrine were put upon its defence, and not allowed to establish itself without due scrutiny. —*Mich. Med. News.*

How to Make a Poultice.—At first sight the title of this paper may seem absurd to many of our readers, and the idea that medical men require any instruction in making a poultice preposterous, but we have been led to write it from seeing that many students and some practitioners do not distinguish between the proper methods of making a poultice for surgical and for medical use. Many, perhaps most, students spend a great part of their four years' curriculum in surgical study, and devote a comparatively small portion of it to medicine. This may partly be the reason why they do not learn the best ways of making poultices for the relief of internal pain : but another reason is, that in hospitals poultices are made in certain ways for the sake of cleanliness and economy, and these ways are not always the best possible for private patients, although they may be the best under the conditions which obtain in hospitals. Every one knows the relief which a poultice affords when the finger is inflamed, and has noticed how the painful throbbing diminishes after its application. Most people have noticed also that dipping the finger in cold water has a similar action, and it seems strange to many that the opposite conditions of heat and cold should have a similar effect. The reason probably is that both heat and cold

lessen the force of the impulse with which the blood is driven through the dilated arteries of the inflamed parts against the block which exists in the capillaries. Cold causes the afferent arteries to contract, and lessens the impact of the blood by diminishing the quantity sent to the inflamed part; a poultice lessens the impact by dilating the capillaries surrounding the seat of inflammation and affording a ready side outlet into the veins. In surgical cases we usually use the warmth and moisture of the poultice to act directly on the surface. We therefore make the poultice with crushed linseed or with linseed meal and oil, spread it on some tow and apply it to the skin without anything intervening. But useful though this method may be for wounds, ulcers and abscesses, it is not the best form of application in cases of inflammation of the thoracic or abdominal viscera, or where spasm is present without inflammation. In such cases we may, no doubt, do some good by applying the poultice to the surface exactly as in surgical diseases. We may draw off some of the blood to the surface; and we may also exercise a reflex action through the nerves upon the vessels of the inflamed organ below, but this will not be so great if we influence the surface only, as when we allow the heat to penetrate to the inflamed or irritated organs themselves. If we apply the poultice directly to the skin, it must be allowed to become tolerably cool before the patient can bear it, and thus half its advantage is lost. In order to relieve spasm, as in colic—intestinal, biliary, or renal; to relieve inflammation of the pleura, the lungs, the liver, or other organs, we want to apply the poultice as hot as possible, while we protect the skin from being scalded. In order to do this, a flannel bag should be prepared, a convenient size being 12 inches by 8; this should be closed at three edges and open at the fourth; one side of it should be about one inch or one inch and a half longer than the other, and it is convenient also to have four tapes attached at the points which form the corners when the bag is closed, in order to keep the poultice in position. Besides this, another strip of flannel should be prepared of the same breadth as the length of the bag, and long enough to wrap round it once or oftener. Crushed linseed, bowl and spoon should then

be got together, and the spoon and bowl thoroughly heated by means of boiling water; the poultice should then be made with perfectly boiling water, and rather soft. As soon as it is ready, it should be poured into the bag, previously warmed by holding it before the fire; the flap, which is formed by the longest side of the bag, should now be turned down and fastened in its place by a few long stitches with a needle and thread, it should then be quickly wrapped in the strip of flannel (also previously warmed), and fastened *in situ*, if necessary, by means of the tapes. It may be covered outside with a sheet of cotton wool. In this way the poultice may be applied boiling hot to the skin without burning; the two layers of flannel, which are at first dry, allow the heat to pass very gradually indeed to the skin; as the moisture of the poultice soaks through them, they become better conductors, and the heat passes more quickly, but the increase is so gradual as not to cause any painful sensations whatever, but only one of soothing and comfort. The poultice also naturally keeps much longer hot, and the necessity for changing it arises much less frequently. The difference between the effect of a poultice made in the ordinary way, and in the manner just described, is sometimes exceedingly striking. It is, perhaps, less marked in cases of inflammation than in those of spasm. We have seen a patient suffering from intense abdominal pain at once relieved by a poultice made in the way just described, although a succession of poultices made in the ordinary way had been utterly useless. This way of making poultices is one of the minutiæ of medical practice; apparently extremely trivial, but really, we believe, very important. The relief which we have seen afforded by poultices made in this way, and the knowledge that *some* practitioners at least are ignorant of the method, must be our apology for drawing attention to such a trivial detail.—*Practitioner*.

The Oleates and Oleo-Palmitates in Skin Diseases.—In this abstract of a paper read before the Pennsylvania State Society, the author calls attention to the oleates prepared by Dr. Lawrence Wolff, of Philadelphia, as being chemical compounds of a definite and stable character—

true oleates—instead of mere solutions of oxides in oleic acid, heretofore manufactured. They are produced by the double decomposition of sodium oleates with solutions of neutral salts. For economy's sake, the oleo-palmitates, double salts of oleic and palmitic acids with the metals or bases required, may be employed as substitutes.

In the course of his remarks, the writer deals more particularly with the oleates of mercury—zinc, lead, copper, aluminium, bismuth, iron, arsenic, and silver—showing their modes of preparation and the special advantages enjoyed by each in the diseases to which it is applicable. Thus, the *oleate of mercury* is stated to be the best local stimulant and alterative of all the mercurials. It is employed with success in the inunction treatment of syphilis, in the chronic stage of psoriasis, and for the thorough destruction of parasites, both animal and vegetable.

Oleate of zinc is the remedy *par excellence* for excessive sweating, or in cases of hyperidrosis and osmidrosis, and is the most reliable application in that commonest variety of eczema—*eczema vesiculosum*.

Oleate of copper has effected rapid cures in cases of ringworm.

Oleate of bismuth is particularly useful pencilled over rosacea; it often subdues intractable cases of this disease; it has also been found very serviceable in sub-acute gonorrhœa and gleet, when smeared on a bougie, and thus introduced into the urethral canal for a few moments.

Oleate of iron will, no doubt, take the place of other chalybeates—particularly when the latter are not well borne by the digestive organs—and will probably constitute one of the best constitutional tonic and local astringent remedies.

Oleate of arsenic has been used satisfactorily in the ulcerating varieties of lupus and epithelioma.

Oleate of silver is a safe and efficacious remedy in erysipelas.

The superior advantages which the oleates possess over ordinary ointments are considered under the following heads:—1. Their deep penetration. 2. Their freedom from rancidity. 3. Their cleanliness of application. 4. Their great economy; they only require to be lightly smeared or applied over the

surface in very small quantities. 5. Their antiseptic and deodorant action.

A great drawback to the general adoption of the oleates will be the lack of knowledge that the majority of pharmaceutical chemists have, at the present time, of their manufacture. Thus, after prescribing a certain oleate, and seeing no change in his patient, Dr. S. has frequently found that either some other article or an oleic solution had been substituted for the remedy ordered. Good, honest chemists, however, if they do not understand the manufacture of the oleates, will procure them for their customers, or will go to work and make them; but their products should always be examined and seen to possess all the physical properties of true and stable oleates.—*J. V. Shoemaker in Med. Bulletin.*

Goitre.—Dr. Danon, in his *thèse*, thus reviews the treatment of suffocating goitre: Medical treatment (iodine *intus et extra*) only succeeds in glandular hypertrophied goitre, and perhaps sometimes in the cystic tumor of recent date, small, soft, and superficial. When the goitre is recto-sternal mobile, the surgeon should endeavor to raise the goitre with his fingers and seek to retain it in that position by means of four pins thrust into the goitre, or by the metallic drain invented by Fauvel. This operation is termed "suspension" of the goitre. When the tumor is cystic, and does not present immediate danger of suffocation, the operator can choose between sub-cutaneous puncture, which is only palliative, cauterization, which occasions always great pain, prolongs the treatment, and leaves ugly cicatrices, injection of iodine, which produces for some days after a swelling that might be dangerous, interstitial or subcutaneous injection of iodine, according to the method of Velpeau, or finally, the metallic drainage, to be followed by the elastic drainage. In *solid* goitre, after having tried internal treatment, the choice will only be left between interstitial injection and drainage. In vascular goitre ligature of the thyroid arteries might be attempted, or injections of perchloride of iron. When the goitre is cystic, and suffocation imminent, it should be tapped

if it is soft and superficial, and a drainage-tube placed. If the tumor is solid, and the attacks of suffocation frequent, extraction of the thyroid gland is the only resource. Tracheotomy should be reserved for cases where the life of the patient is in immediate danger. Igni-puncture and interstitial injection of chloride of zinc have been recently employed with good results, but the cases require to be more numerous in order to be able to accept this treatment in a definite manner.—*Med. Press and Circular.*

Attempt at Suicide.— Dr. S. B. Ward read a report before the Medical Society of the County of Albany, of a case of serious but unsuccessful attempt at suicide :—

T. B., æt. 38, inmate of the Penitentiary, on 30 years' sentence for counterfeiting, on July 10, with suicidal intent, cut his abdomen, tried to divide the right carotid, and then severed the left brachial artery an inch above the elbow. He did this in his cell at night, and was not discovered till next morning. Dr. H. R. Haskins, surgeon to the penitentiary, found him exsanguinated to the last degree, with no pulse at the left wrist and very little at the right. There was a wound one and a quarter inches long over the left brachial, but the artery was not in sight ; one in the abdomen seven inches long, extending from a little to the left of the umbilicus to the ensiform cartilage, through which protruded the stomach, large and small intestines with omentum, which was gashed in several places, and a distinct amount of fecal matter was on the skin, the viscera having been further cut after protrusion. The intestines were cold and dry, somewhat adherent, and had fuzz from the blanket sticking to them. Being apparently moribund, the parts were wiped with a dry handkerchief, and after an hour returned, immediate attempt causing hiccough and severe pain, and the wound closed with eight sutures, not through the peritoneum, broad bands of plaster being applied round the trunk. The other wounds, bleeding having ceased, were brought together with plaster only. He was kept steadily under the influence of morphia, and after forty-eight hours was removed to the prison hospital. For four days he did not raise his head or move hand or foot.

At the end of that time sutures were removed, the wounds having nearly healed by first intention, about an inch of the abdominal wound being still open, but healed at the bottom when I saw him, July 27, by the kindness of Dr. Haskins, who gave me permission to use the history of the case. This has gradually filled by granulation. He had had very little pain, and no evidence of peritonitis at any time. The tongue has been clean, the pulse always below 100, and the temperature never notably above normal Morphia was discontinued on the 11th day, and the bowels moved voluntarily on the fourteenth. A firm cylindrical mass occupies the place of the brachial artery, where it is wounded, two inches above pulsation being felt. Pulsation is perfectly plain in the left radial, showing that collateral circulation is established. He was returned to duty Nov. 1. The knife used was one he had made from the steel spring which goes in the shank of a lady's gaiter, its blade $\frac{3}{8}$ of an inch wide, two inches long, thin, pointed and well ground. Suicide was probably attempted under an insane delusion. Death would probably occur in such a case from hemorrhage, shock or peritonitis. The completeness of division of the brachial, with a possible bending of the elbow, checked the hemorrhage probably; the warmth of the weather, with the covering by the blanket, prevented shock from cold; as to peritonitis, the intestinal wounds being inflicted after protrusion, no fecal matter probably entered the peritoneum, and from long exposure all oozing had ceased before their return, the wounds also probably being already closed by exudation begun, but the greatest factor in preventing peritonitis was the copious bleeding.—*Med. Annals.*

The Significance of Koch's Discovery.—In a recent letter to the Berlin Reichsgesundheitsamte, Professor Billroth discussed some of the practical aspects of Koch's discovery. He pointed out how the accumulating knowledge of the coarser pathological relations of tubercle have led to the conviction that the discovery must shortly come, and he paid a tribute to the investigations of Villemin as having constituted the first and greatest step in the discovery—the step of demonstrating that tubercle is inoculable. This proved its dependence on a

transferable virus, although we are only now able to eliminate the possibility that the virus might be of simply chemical nature. The various degrees of individual proclivity to suffer, observed in man, render it very important to study the variations of proclivity which are observed in animals. As a rule, it appears that the carnivora are less susceptible than the vegetable feeders (an unpleasant fact, by the way, for vegetarians). In the case of man, the only safeguard is the normal unsuitability of the soil, apart from the existence of inherited fitness. But another reason why local tubercle often exists without general infection—why, for instance, scrofulous caries of a rib so often exists without a general infection—is due to mechanical conditions. At the periphery of such a tubercular focus, in a bone or a lymphatic gland. there is an induration which probably hinders the exit of the tubercular organism and its passage into the blood-current. The necessity of a high temperature, such as that of the blood, for the growth of the organism, probably lessens very much the extent of the disease in man, since, if the germs could develop out of the body, they would probably be ubiquitous. While the discovery of Koch raises even into greater importance than before the inherited predisposition, it will probably lead to some modification of our views as to the influence of that predisposition. Cases may be due to infection which are regarded as the result of inheritance only. A consumptive mother, for instance, may infect a child through a pocket-handkerchief; moreover, the germs may be received by eating the flesh of infected animals. Certainly the conclusions are sufficiently probable to make it inincumbent on us to treat consumption as in a measure an infectious disease.—*Practitioner.*

The Antiseptic Treatment of Typhoid Fever.—At a meeting of the Société Médicale des Hôpitaux, June 9th, M. Ferrand presented the candidate's thesis of Prof. Desplat of Lille, upon the comparative action of carbolic acid and salicylate of soda. The views presented were that the above drugs were excellent antipyretic and antialgesic agents—sure, rapid, and permanent in their action, but, at the same time, easily eliminated, and, therefore, but slightly dangerous. Except in

acute rheumatism, M. Desplat did not find any marked difference in their action. The discussion which ensued turned upon the use of carbolic acid in typhoid fever. Thirteen members took part and related their experience. Three or four did not commit themselves; the remainder agreed in saying that the drug in question, used as recommended, had a dangerous tendency to depress the system, and to produce pulmonary congestion, exhausting sweats, and albuminuria or polyuria. It was unanimously voted that the use of carbolic acid in typhoid fever, when given as recommended (in half-gramme or gramme doses by enema twice a day), was dangerous, and without effect upon the course of the fever.

Dr. Ramonet, Physician-in-Chief at the Military Hospital of Boghar, in Algeria, has contributed an article upon the use of carbolic acid in typhoid fever, expressing directly contrary views to the above. He is a follower of Desplat, except that he uses smaller doses, generally not more than two grammes per diem, by injection. The effect, he says, is to lower the temperature nearly 4°F., and to produce a most favourable change in the progress and symptoms. He has treated forty-one cases. with a mortality of only two, or 4.0 per cent· The average mortality from this disease in the army is 21 per cent.

On August 22nd, at the Academy of Medicine, M. Vulpian read a paper upon the use of salicylic acid in typhoid fever. M. Vulpian based his therapeutics upon the theory that there is a *bacillus* of enteric fever in the intestine, and that this *bacillus* ought to be ferreted out and killed with an antizymotic. Having tried iodoform, boric acid, phenate of soda, and salicylate of bismuth with no effect, he finally settled upon salicylic acid. This in daily doses of two or three grammes was ineffective, but in doses of six or seven grammes daily (gr. xl. to gr l. every two hours!) most satisfactory results were obtained in a lowering of the fever and a general amelioration of the symptoms. M. Vulpian concluded that this drug, without being curative, had an undoubted modifying influence upon typhoid fever. He thought also that salicylic acid taken by the mouth might act as a prophylactic. The discussion which followed brought out very little.

It was only evident that M. Vulpian's views were theoretical, and that the clinical tests of his reputed remedy were not at all conclusive. Salicylic acid has been tried in Germany and America with no very good results, as yet reported.

A New Test for Albumen in the Urine.—When an albuminous urine is treated with a saturated solution of common salt, not the slightest reaction takes place ; but if the brine be slightly acidulated with hydrochloric acid, according to Dr. Wm. Roberts, the albumen is thrown down as a dense white cloud. This reaction constitutes a most delicate test for albumen in the urine. The best degree of acidulation for this purpose is obtained with about 5 per cent. of the dilute hydrochloric acid of the Pharmacopœia. A little more or less acid makes no appreciable difference in the sensitiveness of the test. Common salt dissolves in about two and a half times its weight of water at 60° F., and an increase of temperature does not sensibly increase its solubility. The salt of commerce is always more or less dirty, and the solution requires filtration to fit it for use as a test. The salt solution should be fully saturated, otherwise the observer is apt to be led into error. In preparing the test with our common English measure, the readiest plan is to mix a fluid ounce of dilute hydrochloric acid with a pint of water, and to saturate this with common salt, and filter. Dilute hydrochloric acid may be replaced by dilute sulphuric, dilute nitric, or dilute phosphoric acid. All these acids are of the same saturating strength in the British Pharmacopœia, and all of them yield with saturated salt solution an equally sensitive reagent for albumen. Even acetic acid may be used, but the delicacy of the test in that case is not quite so great as when it is prepared with one of the mineral acids. The method of applying the briny test is similar to that followed with nitric acid. A portion of the suspected urine is placed in a test-tube, the test-tube is then held very much aslant, and the salt solution is allowed to trickle along the sides of the tube to the bottom, so that it may form a distinct layer below the urine. If albumen be present, a white cloudy zone appears at the junction of the

two fluids. Or the proceeding may be reversed. The salt solution may be first introduced into the test-tube, and then the urine added with the same precautions as before, so as to obtain two distinct layers, one above the other, in the test-tube. It is important to be aware that the precipitation of albumen by acidulated brine is not due to a true coagulation. In this respect the brine test differs from nitric acid and boiling. In the two latter cases the albumen is transformed into the insoluble modification, which is known as "coagulated albumen." But when albumen is thrown down from urine by acidulated brine, the precipitate is not insoluble; on the contrary, it is redissolved by free addition of water, or even by free addition of the albuminous urine itself. It is therefore essential to the efficient application of the test that the salt solution should be in excess at the point of expected reaction. This end is obviously secured in the above described methods of testing. In point of delicacy the salt test stands on a par with nitric acid. The minutest trace of albumen detectable in the urine by nitric acid is also detectable with equal ease by acidulated brine. In high-coloured urine the brine test is distinctly superior.—*Lancet, October* 14, 1882.—*Med. News.*

Two New Antiseptics.—M. G. Le Bon has just presented to the Academy of Sciences two new and very effective antiseptics, the glyceroborate of calcium and the glyceroborate of sodium. Both of these compounds have the advantages of being very soluble, destitute of odour, and free from all toxic action. When exposed to the air they both deliquesce with great rapidity, absorbing from the air an equivalent weight of moisture. Both alcohol and water dissolve twice their own weight of these salts. They are powerful antiseptic agents even in very dilute solution; the most effective in a therapeutic point of view appears to be the calcic salt. It is absolutely innocuous, and it can be applied in strong solution to so delicate an organ as the eye without bad results. In a hygienic sense both can be employed with advantage as disinfectants and as preservers of meat and other alimentary products. M. Le Bon has transmitted meat

simply coated with a varnish of the glyceroborate to La Plata, and it has arrived in a perfectly fresh and sound condition. He thinks both salts will prove very useful as antiseptics in Lister's mode of dressing wounds.—*Medical Gazette.*

Fat Embolism after Fracture.—From a careful study of the cases, and a review of the literature of fat embolism, Dr. A. Minich (*Lo Sperimentale*, 1882, No. 3) has been led to consider that the condition is much more frequent than has been supposed. He concludes as follows: 1st, In every fracture there is more or less fat embolism, though in children it may be wanting or very insignificant, on account of the small amount of fat contained in their bones. 2nd, Very seldom is fat embolism by itself the cause of death or alarming symptoms. 3rd, Non-infectious fat gives rise neither to pyæmia nor inflammation. 4th, Death depends principally upon the suspension of function of the nervous centres, which is reduced by ischæmia. 5th, The presence of pure or emulsified fat in the urine occurs chiefly in severe and dangerous cases of embolism. It may often appear without grave symptoms. 6th, The occurrence of death from fat embolism after fracture must be borne in mind. 7th, The therapy is merely, thus far, symptomatic, and of very little effect in preventing a fatal result.

Treatment of Burns.—Dr. A. H. Buckmeister, ambulance surgeon, Brooklyn, L.I., furnishes us with the following as the treatment he uses in burns. He says: "After trying the various dressings for burns in vogue, and all of them proving unsatisfactory, the following, improvised by the writer, has proved efficacious: To equal parts of linseed oil and water, to which lime has been added (making it about three times the strength of the aqua calcis), there is placed enough sodium bicarbonate to make a thick pasty mass (in severe cases morphia may be added); this mass is applied with loose bandages in the usual way. This dressing has all the advantages of the sodium bicarbonate alone, and does not adhere to the skin. Dr. Brown, House Surgeon to Long Island College Hospital, states that cases brought to him with this dressing gave very good results."

The Last Thing in Incubation.—The *Lancet* is authority for the statement that M. Tarnier, of the Maternity Hospital, in Paris, has had constructed a box which is very similar to the incubators used for poultry. Into this he places all the weakly and sickly children. This box is divided into two compartments, the lower one being used as a reservoir for hot water, while the infant is placed in the upper one, which is well stuffed at the sides, and fitted with a sliding glass cover. The temperature is maintained at 86 degrees, Fahrenheit, and M. Tarnier has found that by keeping infants in the incubator for periods varying from two days to six weeks their vitality is enormously improved. He has made experiments upon five six-months' children, six seven-months' and thirteen eight-months' children, and he has only lost two of them, whereas, according to his statement, three-fourths of them would have died but for this adventitious aid to vitality.

Dr. Holmes on Physical Diagnosis and Specialism.—I have often felt, when seeing hospital patients worried by hammering and long listening to their breathing, in order that the physician might map out nicely the diseased territory, the boundaries of which he could not alter, as if it was too much like the indulgence of an idle and worse than idle curiosity. A confessor may ask too many questions; it may be feared that he has sometimes suggested to innocent young creatures what they would never have thought of otherwise. I even doubt whether it is always worth while to auscult and percuss a suspected patient. Nature is not unkind in concealing the fact of organic disease for a certain time. What is the great secret of the success of every form of quackery? *Hope kept alive.* What is the too fatal gift of science? *A prognosis of despair.* "Do not probe the wound too curiously," says Samuel Sharp, the famous surgeon of the last century. I believe a wise man sometimes carefully worries out the precise organic condition of a patient's chest, when a *very* wise man would let it alone and treat the constitutional symptoms. The well-being of a patient may be endangered by the pedantic fooleries of a specialist.—*Boston Medical and Surgical Journal.*

Paget's Disease of the Nipple.— It is of the utmost importance to come to a definite conclusion with regard to the nature of this disease, whether it is primarily of an eczematous nature ultimately terminating in cancer, or whether it is of a malignant nature from the outset, as the treatment, of course, must vary according to the view we adopt. Prof. McCall Anderson has seen a number of cases of this disease, and believes that in persons predisposed to cancer, any local irritation may determine an outbreak of the disease at the part irritated; thus we have frequently seen an undoubted syphilitic disease of the tongue followed by cancer of that part, as the result of the long-continued irritation; and just in the same way it is possible for a simple eczema of the breast to prove the exciting cause of, and to be followed by, cancer of the mammary gland. But if we exclude these exceptional cases, we can arrive at no other opinion than that "Paget's disease of the nipple" is from the first of a malignant nature, and bears a somewhat similar relation to cancer of the breast that the so-called tylosis (or psoriasis) linguæ does to epithelioma of the tongue. Such being the case, it is of the utmost importance to distinguish true eczema of the breast from "Paget's disease of the nipple," towards which the following may be of assistance :—

1. "Paget's disease of the nipple" occurs especially in women who have passed the grand climacteric. Eczema of the nipple and areola occurs especially in women earlier in life, and particularly during lactation, or in persons labouring under scabies.

2. Affected surface, in typical cases of Paget's disease, of brilliant red colour, raw and granular-looking after the removal of crusts. Surface not so red and raw-looking in eczema, and not granular, but often punctated.

3. When grasped between the thumb and forefinger, superficial induration often felt, in Paget's disease, as if a penny were laid on a soft elastic surface and grasped through a piece of cloth (Thin). Eczema is soft, and no induration.

4. Edge of eruption abrupt and sharply cut, and often elevated, in Paget's disease. Edge not so abrupt, and not elevated, in eczema.

5. Paget's disease is very obstinate, and only yields to extirpation or other treatment applicable to epithelioma generally. The other disease, although sometimes obstinate, yields to treatment applicable to eczema.—*Glasgow Med. Jour., Oct.*, 1882.

Specific for Sore Throat.—After a large number of observations, Dr. Robt. N. Hormazdji, of Cheltenham, has come to the conclusion that in all acute cases of tonsillitis, salicylate of sodium is a specific, while in chronic cases it seems to possess no effect whatever. He recommends about 15 grains of the remedy every hour, till the most urgent symptoms are relieved, when only half the dose is administered. At the same time he employs a gargle, consisting of about 10 grains of the salicylate of sodium, one ounce of glycerine and three ounces of water. He found the remedy specially specific in its effect in very acute and severe cases, as also in the angina of scarlatina and of erysipelas.—*Medical and Surgical Reporter.*

Cholera and Filth.—The exact nature of the relation between cholera and filth is a subject admitting of speculation and discussion, and the question will not be satisfactorily solved until the precise cause of cholera has been demonstrated; but of the reality of the relation as a matter of fact there can be no reasonable dispute. Strong evidence exists in Calcutta which goes to support the doctrine that, whatever the nature or cause of cholera may be, filth has much to do, if not with its origin, certainly with its propagation—filth in air, water and food; filth due to neglected conservancy; fifth consisting mainly of the decomposing excreta of men and animals. The history of cholera in this town points to a marked abatement of the disease coinciding with important sanitary improvements, more especially with the introduction of a supply of pure water, and its distribution in such a manner as to prevent contamination in transit. The most important fact shown by the report of the Health Officer of Calcutta is that the sections which exhibit the lowest general death rates are those in which the sanitary conditions are most favourable, in which the streets are widest and best

kept, the houses largest and sparsest, the drainage most complete and efficient, pure water universally used, and the inhabitants most observant of the rules of hygiene, domestic and individual; while, on the contrary, the sections with highest death rate are the most crowded and filthy, with narrow, muddy streets, often heaped with refuse and rubbish, foul pits and ditches, ill-kept stables and byres, wells and tanks filled with diluted sewage, with numerous *bustis* or villages ill-ventilated, over-crowded and filthy, in which the poorer classes, ignorant and careless as regards cleanliness, mass themselves together in poverty and squalor.—*Indian Med. Gazette, Sept.* 1, 1882.

Transplantation of Muscle from the Dog to Man.—After the removal of a large fibro-sarcoma from the biceps of a woman, aged 36, Helferich filled the gap with a freshly-cut piece of muscle from a dog, fastening it with six lower and thirty upper catgut ligatures. Cure followed antiseptic dressing. The patient can readily flex and extend the arm. Electrical examination by Ziemssen showed no abnormality, and the transplanted muscle seems to have retained its vital functions.—*Berl. Klin. Woch.*, No. 26; *Cin. Lancet and Clinic.*

Egyptian Treatment of Syphilis.—In the course of an article on "Medical Notes of Travel in Egypt," by Dr. Josiah Williams, in the *British Medical Journal*, occurs the following:—"The native treatment of syphilis in young girls is very primitive and very barbarous. Close to the town (Souakin), in the Red Sea, is a little island, called originally Sana Gin, and from which the town takes its name. The girl is taken across to this island by six women; she is then laid naked on her back; on each arm and each leg sits a woman, another on her chest. The operator, another woman, who is provided with a sharp sea-shell, scrapes away in the vagina until she is satisfied that all diseased parts are removed, and then, utterly regardless of the shrieks of the girl, gets a handful of sand from the sea, and rubs that in. The disease is then supposed to be cured by this rather rough operation.

New Method of Treatment of Hypertrophy of the Tonsils.—Prof. Moresco of Cadiz read a paper before the Congress of Seville (*Revista de Med. y Cirurgia pratica*) in which he recommends the treatment of hypertrophy of the tonsils by interstitial injections of acetic acid; he reports two cases perfectly cured by this method. He gives the following as the advantages of this method: 1. Its facility of performance. 2. The impossibility of causing any serious results. 3. The gland preserves its functions. 4. It requires no interference with the patient's occupation. 5. It is absolutely painless.—*Rev. Mens. de Laryngol., d' Otol. et de Rhinol.*, Oct. 1, 1882.

Trichinosis.—The Vienna correspondent of the *Maryland Medical Journal*, describing a recent fatal case of Trichiniasis, remarks:—"An interesting point in the history of the case was the fact that the girl had not eaten any pork, but had lived on horse-flesh and raw liver. The last is not an unusual dish made up into sausage. Authorities have said the horse was not subject to trichinosis. Unless the liver is to blame in this case, the horse can no longer be exempted from this horrible disease. Among the poor classes on the continent horse-flesh is a very common food. I have heard it said that they get no other kind of beef."

A Poison for the Bacilli of Tubercle.—A paper has been recently communicated by M. de Korab to the Paris Academie des Sciences on the action of a substance called *helenine* upon the bacilli of tubercle. He cultivated the *bacilli* according to Koch's method, in bovine serum, which was daily heated for a week, in order to sterilize it. Tubercles from a guinea-pig were then introduced into ten tubes, to three of which the helenine was added. All were kept at a temperature of 37° C. for a week. It was then found that the tubes having no helenine caused tuberculosis when inoculated. Those containing the helenine were innocuous. Some glowing inferences are drawn by M. de Korab from his experiments.—*N. Y. Med. Record.*

CANADA

Medical and Surgical Journal.

MONTREAL, NOV., 1882.

McGILL COLLEGE ENDOWMENT.

In our last number we alluded to the announcement made by the Dean of the Medical Faculty of McGill University that a wealthy citizen had promised, conditionally, the handsome sum of $50,000 towards a permanent endowment of that Faculty. The only condition attached is that, before the month of August next, a like sum shall have been subscribed by others towards the same object. We sincerely trust, and we have every confidence, that this noble generosity will have the effect of stimulating others to co-operate in the same direction. Montreal possesses many wealthy men, and McGill many prosperous sons, who will be glad and willing to help as far as in them lies. They only require to have it clearly shown that this money is really required in a good cause, and we know they will cheerfully respond to the call. There prevails amongst some, even of our thinking men, the erroneous idea that a Faculty of Medicine is, and should be, self-supporting, and that they should give only to those allied departments which furnish a non-professional education to the student. But how far is this from being the case. Of course, a Medical Faculty must, to keep out of debt, govern its expenditure by its receipts, and that of McGill College has always endeavoured to employ all the means at its command, so as to ensure to its students the greatest possible educational advantages ; but, how often, how constantly, have they felt that they were hampered, let, and hindered in supplying that thorough scientific education which is looked for at the present day, through want of a sufficiency of means. In some instances, notably the recent complete furnishing of a Physiological Laboratory, the

funds had to be procured by a private subscription from the professors themselves. Dr. Howard, in his admirable address at the opening of the Session, alluded to a few of the more urgent requirements of the Faculty at the present time, and it is matter for the most sincere congratulation that his timely words should have fallen on such good ground and brought forth fruit so rapidly. This, the oldest of our medical teaching bodies—one which has now for half a century yearly sent out practitioners of the healing art to carry the good effects of their early training throughout the length and breadth of the country—has special claims upon the citizens and the old graduates for support. It has been doing a noble work, and will continue to do so. But the importance of the trust confided to it demands that it shall have the ability, as it has the desire, to give, in every branch, such facilities for the prosecution of purely scientific studies as are expected at the present time from any school wishing to hold a front rank. A permanent endowment will accomplish this, as nothing else possibly can. It will allow of some of our ablest men devoting themselves exclusively to scientific pursuits, as is done in England, on the Continent, and in a few places in the United States. It will allow of numerous clinical assistants to carry on special hospital work with divided classes. It will help to build up a medical library of reference, invaluable to the whole community. It will permit of the extension of the practical laboratories, both chemical and physiological, which can then be provided with still more much-wanted assistants. It will furnish the means for retaining the services of curators for the better arranging and enlarging the Museum. Thus will be built up an establishment for the education of scientific and truly practical physicians—an institution to which the country can point with pride.

An appeal is being made to the old graduates of McGill College to subscribe to this fund—to be called "The Campbell Memorial Fund." We hope many of the old alumni—prosperous as we are glad to know the great majority are—will feel it both a pleasure and a duty to assist in placing their *Alma Mater* in a firm position, and by thus increasing the facilities for future

generations, they will in a measure have repaid some of the benefits they themselves are conscious of having received at her hands.

POISONING BY EXTRACT OF MALE FERN.

It is well to be reminded that this favourite remedy for tapeworm has poisonous properties, and should always be prescribed with due care, especially with regard to individual peculiarities. A case in which death followed its administration recently occurred in India, and might have resulted seriously for the unlucky physician. As it was, a charge of manslaughter was brought against him, but the jury accepted certain explanations and the case fell through.

It appears that Dr. Coghill of Colombo ordered a Mr. Aitken, 30 years of age, a four-ounce mixture containing *an ounce and a half* of the ethereal extract of male fern. The chemist considered it a large dose, but thought it might be dispensed with safety. Half the quantity (representing six drachms of the fern) was taken at bedtime. This caused considerable distress, but as none of the joints were passed, he was instructed to take the remainder of the mixture about noon of the following day. Dr. Coghill was summoned soon after, and found that his patient had purged and vomited a great deal, although he had eaten nothing for some hours. He had, however, passed a large quantity of the worm. Choleraic symptoms continued, the pain only being relieved by a hypodermic injection of morphia, and the patient died about twelve hours after the administration of the second dose. At the autopsy, patches of congestion, and here and there actual extravasations, were found over the stomach and small intestines, the mucous membrane being smeared with a dark-brown fluid having the smell of ether.

At the inquest, it came out that Dr. Caghill was blindly led in his prescribing by the work known as "Naphey's Modern Medical Therapeutics." In a prescription in this book, credited to Dr. William Brinton, it will be found that *ounce* and a half has been substituted for *drachm* and a half as the dose of extract of male fern, and it was this that misled Dr. Coghill.

Of course he can hardly expect to be held blameless on this account, but, undoubtedly, the responsibility should be largely shared by the book in question ; and our object in penning this article has been, as much as anything else, to warn unwary members of the profession, who may be in possession of Naphey's book, against the egregious error above referred to.

Dr. Cobbold, perhaps the greatest living authority on the subject of intestinal worms, referring to this case in a recent number of the *Lancet*, states that he seldom prescribes more than one drachm of the ethereal extract of male fern for a single dose ; but he has known two separate one-drachm doses to cause jaundice in an adult, and half that quantity to produce mental confusion in a child of seven years. He writes further that he has heard of an instance in which three drachms sufficed to produce alarming symptoms. He puts in a strong plea for the drug, and trusts that its fatal employment in the case under consideration will not deter the profession from resorting to it in the treatment of tapeworm. We might add that in our own limited experience, we have found no anthelmintic so efficacious as this in the treatment of tænia.

THE PUBLICATION COMMITTEE.

Ever since the foundation of the Canada Medical Association, it has been customary for the readers of papers at the annual meetings to send their communications to a medical journal for publication. Generally speaking, they have been received by some of our own Canadian journals, but occasionally they have been given to American or English periodicals. It has always, however, been believed that the reader had a perfect right to select for himself the medium through which it should be made public. The only exception that we are aware of was upon the occasion of one of the meetings in Montreal, when all the papers appeared together in a volume of transactions. As almost every member of the Association is aware of these facts, many must have been surprised to find the *Canada Lancet*, in its last number, assuming that, because some of the papers have been

published in this journal, it therefore "has taken upon itself, unsolicited, and without the sanction of the Printing Committee, the self-imposed task of printing the most important papers read at the recent meeting," and suggests that some might look upon this as betokening an aspiration on the part of this journal "to become the organ of the Association." As for years past every Canadian journal has (and very properly) published any of these papers which have been sent to it, without any reference to the Publication Committee, we fail entirely to see the point of our contemporary's remark. As a matter of fact, the Publication Committee has performed no functions and made no report, except on the occasion referred to. But further, the duties of that Committee are thus laid down in the By-Laws: "It shall have charge of preparing for the press and of publishing and distributing such of the proceedings, transactions and memoirs of the Association, as may be ordered to be published." If the *Lancet* really did believe that Committee to be in operation, perhaps it will explain how it occurred that a special report of a very important matter was printed before the meeting, distributed to the members headed "*The Canada Lancet*," and subsequently appeared in its pages, without the sanction of the Committee! The beam in the eye of the *Lancet* has surely caused such distorted vision as produced the semblance of a mote in our eye.

L'UNION MEDICALE AND BISHOP'S COLLEGE.

A little unpleasantness, which threatens to come before the Courts a second time, has been in progress between the parties above named. Some months ago *L'Union* published an editorial article stating that a certain individual asserted that he had been given a private examination by members of the Faculty of a Medical College in this city. From certain collateral evidence, the professors of Bishop's College believed that they were the persons alluded, and with the view of clearing themselves of the accusation, entered an action for criminal libel against the editors of the papers. The grand jury, before whom the case came, brought in a "no bill." The editors, therefore, now retaliate by bringing an action against several members of the Bishop's

Faculty for damages, rated at $10,000 each. If the case goes to trial, no doubt some interesting points will be developed.

Holocaust in Halifax.—A most destructive fire occurred in the Poor Asylum building in Halifax on the night of the 6th inst. The flames appear to have spread with great rapidity, and soon cut off all escape from a part of the building which was occupied by the sick and infirm as a hospital. It is stated that over thirty of these unfortunate creatures perished in the flames. It is hard to condemn without being in possession of full particulars, but it does certainly seem as though sufficient care and forethought had not been exercised in placing a large number of sick and infirm persons together at the top of a building, in rooms from which there were no adequate means of escape in case of fire. This is certainly a point upon which Government inspection ought to be most stringently brought to bear.

—A new edition of the *Ontario Medical Register* has been issued, and presents the usual creditable appearance of the publications of the Ontario Medical Council. We cannot help contrasting it with the carelessly prepared and atrociously printed *Quebec Medical Register*. We gather that there are 1919 names on the register in Ontario, of whom 175 practice outside the Province and the residence of 86 is unknown; so that there are about 1700 legally qualified practitioners in the Province, giving about one to every 1125 of the inhabitants.

—The corporation of McGill University has under consideration the question of the admission of women to the Arts course. The matter has been refered to a special committee. The University of Pennsylvania has decided against their admission, but would be very willing to organize a special department so soon as the necessary funds are forthcoming.

—Mr. T. Berthiaume is suing the *École de Médecine* for $5,000 damages, which he alleges he has suffered through the non-publication, during the last nine months, of *L'Abeille Medicale*. The suspension is stated to have been necessitated by loss of support, the defection of subscribers being due to the extent to which the journal devoted itself to politico-religious matters (the Laval controversy), thus having but little space for scientific medicine.

Obituary.

AARON HART DAVID, M.D., Ed., L.R.C.S.E., D.C.L., &c.

It is with sincere regret that we have to chronicle the death in this city, on the 5th inst., of Dr. A. H. David, the Dean of the Medical Faculty of Bishop's College, and one of the oldest and most respected members of the profession in this country. Dr. David had suffered for nearly two years from a cancerous affection of the abdomen, and fully recognizing the nature of his complaint, had long since calmly resigned himself to what he knew was the inevitable end. Though sometimes he suffered acutely, he retained a degree of cheerfulness which was surprising to his friends. Within the last few weeks, even, he had occupied himself writing out some of his early recollections of medical matters in the city of Montreal, and sent it through his friend, Dr. F. W. Campbell, to be read at the Medico-Chirurgical Society.

Dr. David was the second son of Samuel David, a leading merchant of this city, and was born on the 9th October, 1812. He married, in 1836, Catherine, daughter of the late Henry Joseph, who died in 1876. His first initiation into the study of medicine was as a pupil of Drs. Caldwell and Robertson. He then entered the newly-organized medical school of McGill College. In 1831 he went to Edinburgh, and graduated with honours in 1835, his thesis being upon "The Medico-Legal Proofs of Infanticide." After travelling for a short time on the Continent, Dr. David returned to his native city and commenced the practice of his profession. He served as surgeon to the "Montreal Rifles" during the whole of the rebellion, 1837-39. In 1841 he removed to Three Rivers, where he soon enjoyed a large and lucrative practice. He always followed up his profession with zeal and energy, and resisted many requests to enter the field of politics. He returned to Montreal in 1844, where he had the respect and esteem of a large *clientèle* for a period of nearly forty years. In 1852 he aided in the formation of the St. Lawrence School of Medicine, which, however, fell through after an ephemeral existence of only two sessions. In the same

year, in conjunction with the late Dr. R. L. MacDonnell, he started and edited the *Canada Medical Journal*, which, for want of support, was discontinued after two or three volumes had appeared. In 1849 he was made an attending physician to the Montreal General Hospital, retaining the post, however, only two years, when he resigned in order to occupy a similar position in connection with the St. Patrick's Hospital. In this institution Dr. David also lectured upon Clinical medicine until it was finally merged in the present Hotel Dieu. Upon the establishment of a Medical Faculty in connection with Bishop's College, Dr. David was made Dean and Professor of the Theory and Practice of Medicine, which honorable appointments he held up to the time of his death. In 1871, this University conferred upon him the degrees of M.D. (*ad eundem*) and D.C.L. (*honoris causâ*). He took much interest in the medical branch of the Volunteer Militia service, and did duty as surgeon of the 6th Fusiliers during the Fenian disturbances on the frontier. Having held a commission for the long period of 46 years, he was granted, on resignation, the honorary rank of Lieut.-Colonel.

Dr. David was noted for the great interest he always took in matters pertaining to the general welfare of the medical profession of this country. He was amongst the original founders of the Canada Medical Association, and was always one of the strongest supporters of this general Dominion society. He was elected general secretary in 1869, and most regularly and faithfully fulfilled the duties of that office until 1881. At all meetings of the Association his business knowledge was of the greatest service, whilst his geniality and amiable character made him a general favourite. He was for many years a governor of the College of Physicians and Surgeons of the Province of Quebec.

Dr. David was noted amongst his *confrères* as a man of the strictest integrity and the highest sense of honour, and in these respects he was always an example to young men. He was an able and conscientious practitioner, full of zeal for his profession and anxious for the advancement of the cause of medical education. He was a good citizen, and took an active part in public meetings and in the promotion of charitable objects. He

had an excellent memory, and was always resorted to by his friends when anything concerning the profession long ago needed to be recalled. With Dr. David has gone one of the now few-remaining links connecting the present generation with a past one. He lived a busy and useful life, and died at a good old age, respected and honored by all.

Personal.

Dr. Belfield, of Chicago, will deliver the Cartwright lectures in New York this winter.

Prof. Du Bois Raymond has been made Rector of the Fredrich-Wilhelms University, Berlin.

We regret to learn by the papers that Prof. Virchow is seriously ill ; the nature of the illness was not stated.

Dr. Solly, of Colorado Springs, son of the late Mr. Solly, the celebrated London surgeon, was in town for a few days last month.

The death is reported of Devaine, the discoveror of the Bacillus of Anthrax, and the author of an important work on Parasites.

Dr. J. W. Holland has resigned the editorship of the *Louisville Medical News*, and has been succeeded by Drs. Yandell and McMurty.

Dr. Lefebvre ('78) has left Brockville, having been appointed surgeon on one of the eastern sections of the Canadian Pacific Railway.

H. E. Heyd, M.D. (McGill, '80), and Kenneth McKenzie, M.D. (McGill, '80), have returned from Europe, where they have been studying for the past two years.

Dr. Harvey, of Cleveland, Ohio, has been in town for a couple of weeks. We are glad to hear that he has regained his sight after a successful operation for cataract.

Dr. Stewart, of Brucefield, sailed for Europe on the 17th ult., and intends spending seven or eight months at the chief conti-

nental clinics. The members of the Huron Medical Association presented him with an address and a handsome gold watch, in acknowledgment of their appreciation of his services to the Association.

Medical Items.

—Mr. Clover, the well-known chloroformist of London, is dead.

—Surgeon-Major Boileau reports a very heavy brain, 59.72 ozs., from a highly intellectual man.

—We notice in the *Medical Record* of the 14th ult. that Dr. Leslie, of Hamilton, Ont., has a case of Locomotor Ataxia, with well-marked tendon reflex.

—Helenine, M. de Korab claims, is an antidote to the effects of the bacillus of tuberculosis. He has found that this drug hindered the development of the bacilli in culture fluids, and that its administration will prevent the symptoms of tuberculosis in animals inoculated with the bacillus.

—" How's your rheumatism, Bill ?" " Oh, it's lots better." " Ha, ha ! glad to hear it." " Yes," Bill went on mournfully, " you may say it's lots better ; it gets stronger and stronger every day. But then, I'm a heap worse myself. The rheumatism's all right."—*Hawkeye.*

—184 students have enregistered in the Medical Faculty, McGill College, of whom 62 are new men. Arranged according to Provinces, there are from Ontario, 91 ; Quebec, 44 ; New Brunswick, 15 ; Prince Edward Island, 9 ; Nova Scotia, 7 ; United States, 13 ; Newfoundland, 2 ; Manitoba, 3 ; West Indies, 2. The class in attendance is the largest in the history of the school.

— Philadelphians are now advancing reasons calculated to establish their city as the cradle of American medicine. The first practical instruction in anatomy in America was by Dr. Thomas Cadwalder, in 1750 ; the first permanent general hospital was founded there in 1752 ; the first clinical instruction in America was given there by Dr. Thomas Hurd, in 1756 ;

the first medical library in America was founded there in 1763; the first medical society in America was organized there in 1766; the first medical dispensary in America was established there in 1786; and the first American medical college was organized there in 1765.—*Mich. Med. News.*

Cases of Removal of a Portion of Intestine.—Dr. Wm. Fuller reports, in the *New York Med. Record*, October 14th, three cases of partial intestinal resection for strangulated hernia; recovery took place in all.

Irony of Circumstances.—In Indianapolis, it so happened that the doctors' convention was held first, then the druggists', and lastly the undertakers'. That is generally the way it goes! First doctor, then druggist, then undertaker.—*Indianapolis Pharmacist.*

A Pattern Patient.—A physician, much attached to his profession and his own skill, during his attendance on a man of letters, observing that the patient was very punctual in taking all his medicines and following his rules, exclaimed in the pride of his heart, "Ah, my dear sir, now you deserve to be ill!"

Dermatology Simplified.—A century ago John Hunter divided all skin diseases into three classes: one of which is cured by mercury and the iodides, a second by sulphur, and a third class which the devil himself can't cure. Dr. L. P. Yandell, who quotes Hunter as above, is given credit for a much less complex classification than even this. He attributes all skin eruptions to malaria. Quinine is a specific for malaria—ergo, quinine is the remedy for all skin eruptions.—*Mich. Med. News.*

A Man of Great Brain.—According to our excellent contemporary, *Knowledge*, the "heaviest brain ever weighed in the United States was taken from the skull of James H. Madden, who died at Leadville on July 6th. The doctor who attended him during his last sickness had observed the immense frontal and lateral development of his head, and determined to weigh the brain, but his astonishment was great when it brought down

the scales at sixty-two and a quarter ounces. Cuvier's brain weighed sixty-four and a half ounces, considerably surpassing all other records; but the brain of Napoleon, Agassiz and Webster, although phenomenally heavy, were much lighter than Madden's. It is an interesting circumstance that Madden was not a naturalist, a soldier or a statesman, but a gambler."—*Mich. Med. News.*

Domesticity as a Cause of Insanity.—Mrs. ——, aged 44, mother of eight children, had acute mania. The husband, when asked if he could suggest any cause for her illness, exclaimed with much animation that he could not conceive any reason. "She is a most domestic woman; is always doing something for her children; is *always* at work for us all; *never* goes out of the house, even to church on Sunday; never goes gadding about at the neighbours' houses, or talking from one to another; has been one of the best of wives and mothers, and was *always* at home." The superintendent, in commenting on this case, says: "This appreciative husband could hardly have furnished a more graphic delineation of the causes of his wife's insanity, had he understood them never so thoroughly."—*Report of Hartford Retreat for Insane.*

Surgical Outfits for Railways.—The Pennsylvania Railroad Company has purchased two thousand tin boxes containing a few simple surgical materials likely to be used in case of accident. The boxes are kept on the locomotives. Each box contains 1 rubber compress, 1 package of absorbent cotton, 6 rolls of bandages, 1 pyramid of pins. This outfit must always be kept up, and when anything is needed requisition should be made at once. With the box are the following simple directions:—When an arm or leg is crushed, causing hemorrhage, pass compress around limb immediately above the injured part. In case of rupture, if a vein, tying it lightly until arrival of a surgeon. The rupture of an artery can be distinguished by the colour of the blood, which is red, and spurts out, while a vein has black blood and flows continuously. For wounds on the head or face, apply absorbent cotton, and bind with a bandage. The com-

pany deserves great credit for the humanity and forethought shown in the adoption of this scheme.—*Med. Record.* Other railways might with great propriety follow this good example.

An Improbable Interview with Mrs. Langtry.—It is rumoured that Mrs. Langtry, the English beauty, has been interviewed by a medical reporter. She said that she was not a homœopathist, as had been stated; she believed in the New York code, however. Her impressions of American medical men had so far been very favourable, and confirmed previous anticipations formed by a constant reading of the *Medical Record.* The branch of medicine in which she had been chiefly interested was dermatology; in this America easily led the world, and she was sorry she could not have got over in time for the Newport meeting of the Association. She attributed the beauty of her complexion to a constant study of American dermatological literature. Mrs. Langtry was hardly prepared to give her opinion of Post-Graduate Schools, but thought they were very nice. She would send tickets, she said, to any doctors not connected with some medical school—it seemed such a pity. The reporter told her, however, that there were none such. Mrs. Langtry preferred to take her medicines in pill form. She liked the oval-shaped, sugar-coated ones best. Mrs. Langtry asked about our insane asylums, and strongly urged the use of the tight-fitting jacket called the "Jersey," as a substitute for camisoles and straight-jackets.—*N. Y. Med. Record.*

The Calamity in the Seguin Family.—On Wednesday morning the public were startled with the dreadful announcement that the lovely wife of Dr. C. E. Seguin, of this city, had, in a fit of temporary insanity, shot all of her little children—three in number— and afterwards herself. She had taken them to an upper room, tied their hands behind their backs, and then, under the pretext of playing "blind man's buff," first killed the eldest, a beautiful boy of six years, then two sweet little girls, aged respectively five and four years, and evidently in an instant afterwards took her own life. When found in the even-

ing, some time after the commission of the deed, all were dead. The lady was of a most lovable disposition, had been devoted to her husband and family, and had shown no symptoms of insanity except occasional attacks of melancholia, for which she could not account, and which she bravely endeavoured to overcome. Her devoted husband, with an affectionate concern for her condition, had arranged to have her accompany him on a pleasure trip the next day; but he came home in the evening to find himself suddenly deprived of his entire family. A greater calamity could not befall any one, and coming thus upon Dr. Seguin, calls forth the deepest and most heartfelt sympathy of his many friends. May he have the strength to bear this terrible affliction.—*N. Y. Med. Record.*

New Parasites.—We have before us a clipping from the editorial columns of a daily paper, in which the recent investigations of Koch are humorously referred to. The editor then goes on to state that, "While Germany has thus given to the world a discovery of presumably vast importance, Wisconsin has not been idle. Dr. Buhl, a distinguished physician of that State, has just made a discovery as to the origin and proper treatment of broken legs, which is, on the whole, rather more valuable than the discovery of Professor Koch. It has long been noticed that broken legs prevail in thickly settled parts of the country much more generally than in thinly settled regions. It is also undeniable that wherever railroads penetrate, broken legs become common. These facts are sufficient to enable us to assume that there is something in thickly settled regions that is favourable to the development of broken legs, and that this something—whatever it may be—is carried far and wide by railway trains. Dr. Buhl, who is an ardent believer in the germ theory of nearly all diseases, claims that he has discovered a vegetable parasite which infests the human trousers and causes broken legs. Within the past year he has examined with the microscope 36 cases of broken leg, and in every case has found this parasite in the accompanying trousers. In the course of the last six months he has placed garments cut after the manner of trousers and inoculated with the parasite in question upon the fore-legs of

18 cats, 13 of whom were afterwards found in a steel-trap, set for the purpose in the doctor's back yard, each with a fore-leg broken. He also tried a similar experiment upon seven cows belonging to his wife, six of whom were afterwards run over by railway trains—the White River and Sheboygan Railroad running directly through the cow pasture—and sustained compound fracture of more or less of their legs. Having thus fully established the fact that broken leg is produced by a parasite infesting the trousers, Dr. Buhl maintains, and with much plausibility, that by inoculating human trousers with this parasite after it has been artificially bred in trousers supplied for the purpose to cattle, men will be fully protected against broken legs. So far as the non-scientific mind can perceive, the Doctor's plan is an admirable one. If we can by so simple a measure as the inoculation of trousers put an end to the widespread havoc yearly wrought by broken legs, humanity will owe to Dr. Buhl a debt which it can never repay, and the name of Buhl will be inscribed on all sorts of monuments by the side of the equally revered names of Koch and Jenner.—*Medical News.*

Vaseline.—This article has become almost indispensable. We are, however, most familiar with its external employment. It is not unlikely, though, that it may prove to possess valuable properties when administered internally. It has recently been very highly recommended by a competent observer as a prophylactic in diphtheria and whooping cough. It deserves a trial in these diseases.

Subacute Atonic Dyspepsia.—By J. R. Black, M.D.—"The preparation I have found to answer a most admirable purpose in such instances is neither strictly a food nor a medicine, but a sort of nondescript, betwixt and between. I allude to maltine, pepsin and pancreatine. As is well known, it is the half-way digested albuminoids and saccharine elements of wheat, barley and oats. Largely abounding in diastase, and charged with the elements needful for carrying on the digestive process, all that is needed to complete the gastric process on a small quantity of appropriate food is heat and the vermicular action of the stomach. On more than one occasion have I noted, during the past few years, the invaluable properties of the above preparation, after all other resources had failed. For the debility succeeding the acute diseases of those whose stomachs are inherently weak, or for the irritable and weak state which the long-continued administration of medicines for some other disorder oftentimes engenders in the digestive organs, for the failure of energetic action during exhausting processes—as lactation, or large suppurative discharges, as well as for the gastric feebleness often attendant on tuberculosis—peptic maltine fills a place that no other preparation does, and in a truly satisfactory manner. It is altogether constructive; it is bland, even more so to the stomach than any food; it is not nauseating."—*Cinn. Lancet and Clinic.*

CANADA

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REST AND TRACHEOTOMY.

By GEO. W. MAJOR, B.A., M.D.,

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(*Condensed report of a paper read before the Canada Medical Association, at Toronto, September*, 1882.)

The therapeutic value of rest in medical and surgical disease, now so thoroughly recognized, applies with no less force to the various diseases of the throat. There still seems to be a certain amount of doubt and indecision as to the best means of securing this end. In tonsillar inflammation, how keen is the suffering of the patient in attempting to swallow saliva or nourishment. This pain is largely the result of motion, and would at once suggest to a thoughtful practitioner the idea of rest. Perfect rest cannot be secured; modified rest can be, and yet how common it is to order a gargle. By gargling, I mean gargling in the common sense of the term, in which act the head must be thrown back, the liquid held between the anterior pillars, soft palate, and the base of the tongue, the air forced up to throw the liquid into motion, requiring a forcible expiratory effort, indicating the presence of motion and the absence of rest; when an inspiration is necessary, the head must be thrown forward, so as to prevent the passage of the liquid beyond the anterior pillars and velum, otherwise a drop of liquid would of necessity enter the larynx

and produce a violent paroxysm of coughing—a further violation of rest. The needlessness of this procedure is evident. The expiratory effort does not bring the liquid any more thoroughly in contact with the inflamed part, and necessitates a degree of movement detrimental in every way. A gargle is at best a mouth-wash ; it does not come in contact with the diseased surface as a rule, it certainly does not come in contact with the pharyngeal walls, it may, under exceptionally favourable circumstances, with the tonsils or perhaps posterior pillars. When a gargle is necessary, the head need only be thrown back for a moment, during which time respiration is suspended. The thoroughness of this application will be found quite equal to any more complicated movement. If any doubt should exist as regards the mechanical principle of the gargle, it can be simply demonstrated by the use of a coloured liquid, which will leave its stain on all parts with which it comes into contact. The examination must be made immediately after the ejection of the liquid, otherwise, in swallowing the residual portion may lead one astray, by colouring parts before unreached. It is a common habit for a patient to rinse the mouth after using a gargle ; this procedure defeats the only good a gargle can do, for it removes from the mouth any small portion of medicament left in the salivary secretions which, in the act of swallowing, would necessarily come in contact with the parts we seek to affect.

But it is more especially in relation to the necessity of physiological rest of the larynx proper that I desire to speak, and hope to show that all treatment, general and local, of acute and chronic diseases of the larynx, in which the principle of rest is violated, places practitioner and patient at a great disadvantage. We recognize two especial functions in relation to the larynx—the respiratory and phonatory, not to mention that of deglutition, in which latter the larynx is unavoidably concerned. In the respiratory act the intrinsic muscles are almost constantly engaged in active work. Each inspiration enlarges the rima, by separating more widely the vocal bands ; when this act is complete, there is a slight pause, then expiration begins, and with it more muscular action, though of a nature less forcible than that

required on inspiration. During mental or physical excitement the number of respirations per minute increases in order that the pulse-respiration ratio may be maintained. This increase means additional work thrown upon heart and larynx alike. In affections of the heart, organic and functional, we are most careful to avoid everything that will tend in any way to increase the amount of work the central organ of circulation is called upon to perform. In laryngeal disease many of us have yet to learn this lesson. Phonation, unlike respiration, is immediately under our personal control, and every effort in that direction, whatever its intensity or quality, involves to a greater or less extent the approach of the vocal bands. The amount of movement and tension necessary is in direct proportion to the intensity of the effort and the length of time through which it is sustained. The injury resulting from this movement will depend largely upon the diseased condition and the parts involved. In public speakers, where, as a rule, only the vocal bands are affected (thickened), the hoarseness of tone gradually disappears on using the voice, but not without leaving an after sense of fatigue. This, perhaps, argues in favour of a certain amount of exercise. Where, however, pain is evinced, absolute rest, of course, suggests itself.

It might be as well here to call attention to the fact that whispering is not rest, but, on the contrary, involves much more fatigue, distress, and effort, than speaking in an undertone. In the production of a whisper, the vocal bands are held in a position midway between adduction and abduction sufficiently close to produce a rushing sound when the current of expired air meets them, but not near enough to permit of vibration of the bands. Over-rest, on the contrary, might, on general principles, be regarded as detrimental. No joint can sustain absolute rest for a very prolonged period without detriment: the articular surfaces become changed, less elastic, and more vascular, giving rise to pain in motion. This latter statement might be held to apply to the articular surfaces of the laryngeal cartilages, where pain and a tired feeling result after use. There is a difference between laryngeal and other articular surfaces: that whereas, in the latter, mechanical appliances aim at and attain perfect

rest, in the former, rest from phonation is not absolute rest, as the function of respiration is maintained, entailing gentle, but constant motion, asleep or awake; so that the danger resulting from perfect rest in other joints does not, in its entirety, apply to the larynx, unless under the conditions developed by directing the current of air through an artificial channel, which will be noticed in speaking of tracheotomy, as the only means of securing absolute, perfect rest.

Speaking in general terms, the degree of rest necessary to be enforced in any given case must depend largely upon the morbid condition, the continued laryngoscopic examination of the patient, and the experience and judgment which the practitioner may bring to bear in conducting his experiment. In acute laryngitis, absolute rest of the voice becomes the most important factor. All efforts, mental or physical, which would tend to increase respiratory action must be desisted from. Every infringement of this rule must only increase the obstinacy of the attack. Rest may be supplemented by other means of an antiphlogistic nature, but I do not hesitate to say that, in a large majority of cases, rest in itself will be sufficient. Where much constitutional disturbance exists, the internal administration of remedies will, of course, suggest themselves. Soothing inhalations will be found valuable, as also the application of ice externally. Inhalations should not, however, be used when the submucous tissue is involved, otherwise increased swelling will result. In the use of inhalations some caution is necessary. An inhalation should not be used at a higher temperature than 140°F., nor for a longer period than five minutes at each sitting, nor should more than 10 or 12 inspirations be taken in each minute. The violation of these rules will only lead to exhaustion, exhaustion to over-action, and over-action to defeat of the principles of rest. The internal administration of bromide of ammonium I find especially useful, and attribute its benefit to its local anæsthetic power and the rest thus secured.

In chronic laryngitis, we meet with somewhat different conditions. The action of the intrinsic muscles is interfered with, as in these cases, especially if of long duration, more or less

plastic exudation between the muscular fibrillæ has been thrown out, and must, of course, be got rid of before we can expect restoration of the functional activity of the vocal bands, which we find more or less thickened and congested. However valuable the local treatment by stimulants and astringents may be, and however near we may approach, through their aid, to a satisfactory cure, we shall find that here, also, rest is necessary, otherwise we may hover on the verge of convalescence, without ever attaining it. However well the larynx may appear to a cursory observer, on testing the production of the voice, we shall find the tension of the bands interfered with, owing to the loss of muscular power sustained. Moreover, we may have added an involvement of articular surfaces, which, in itself, will present an obstacle of no small proportions, however otherwise healthy the mucous and muscular condition may be.

Subacute laryngitis occupies an intermediate position, and no rule can be dogmatically laid down for observance of rest. Fighting off the effects of cold or hoarseness by increasing the muscular strain cannot, in my opinion, but be productive of harm.

A variety of opinion exists with regard to the extent to which rest should be carried out in these cases. They are extremely common, and if each case were treated on its own merits, I do not think such divergence need exist. As a general rule, some faulty method in voice production, over use of the voice, or singing unsuitable music, will be found to be the origin of the evil, and we should at once seek to find a remedy from such a cause. These cases usually occur in professional voice users, among those who cannot avail themselves of phonetic rest; we must therefore caution them to secure as much rest as possible, by making the amount of vocal work small, by using the voice for short intervals, and by ceasing from all vocal exercise, if possible, should fatigue or pain present themselves, until such a time as we can see that the tensor and adductor muscles during efforts of phonation act with promptness and vigor. If we see an oval chink, even during rendering of high notes, we may safely say that we must look to complete rest for the only remedy. Should we persevere in the use of the voice, we may look for

total disability, a condition that more frequently follows subacute than acute disease. It is through operative interference alone that we can secure to the larynx perfect and absolute rest. I shall trust to a short narration of a few of the cases that have presented themselves to my notice for the vindication of the principle. I shall not attempt here to overcome the prejudice of the laity and profession against opening the air passages, except in cases *in extremis*. I am satisfied, from my own experience, however limited that may be, that were this operation resorted to more early, this prejudice would largely cease to exist. In diphtheria, for instance, the operation is resorted to, generally, when the mechanical obstruction to breathing is so great that suffocation must otherwise result.

In diphtheria of the pharynx and neighbouring parts, I have been in the habit for the past two or three years of carrying out the suggestion originally offered by Dr. Morell Mackenzie, of coating the surface with an ætherial solution of a gum, applied by means of an atomizer. Dr. Mackenzie advanced the idea that these applications acted by excluding air and preventing absorption of moisture. I certainly agree with him in this opinion, but also consider that they act through the rest they secure. The irritable condition of the fauces existing in this disease is thoroughly well recognized, the contracting power of disseminated patches most likely being the cause, as I have observed that where the surface was pretty equally covered, the irritability seemed less. This varnish (for such it is) seems to equalize the tension and render this cause of discomfort much less. The application, though at first smarting, gives relief to reflected pain. This relief I greatly attribute to the rest obtained. If diphtheritic exudation in the larynx were more closely followed by the intelligent use of the laryngoscope, timely operative interference would probably yield much better results, as we should, at least, render ourselves sooner independent of the passage rendered unequal to its work, not only by the mechanical interference of the membrane itself, but also by the influence which the presence of the foreign body has in producing spasmodic action of the adductors. We should also be in a much better position to contend with the

constitutional poison by at least affording a full and sufficient supply of pure air, leaving altogether out of the question the important factor of rest.

Last October, 1881, a young person was referred to me for admission into the hospital for an acute disease unrecognized. Her voice seemed to me somewhat muffled—so much so, in fact, that I at once suggested and carried into effect a laryngoscopic examination. The result was that I discovered, at the anterior commissure of the vocal bands, and extending somewhat more to the right than the left, a patch of diphtheritic exudation, irregular in shape, and of the area of a split currant. On rhinoscopy, some small patches were found in the posterior nares. On the following day the membrane in the larynx had extended over the anterior half of the right cord, violent spasmodic breathing being the result. Forty-eight hours afterwards I was forced to resort to tracheotomy. Owing to the irritable condition of the stomach, I ceased to administer drugs, relying solely upon nourishment and sprays to the posterior nares and larynx. I watched carefully the condition of the larynx; the exudation ceased to extend, the congestion was relieved, and the patient's condition improved, so much so, that in ten days more I was enabled to withdraw the tube. As some interference with abduction still existed, owing, I presume, to spasm of the adductors, I enjoined perfect rest of the voice and the avoidance of active pursuits. This case in itself contributes in some slight degree to uphold what we may look for in rest, other things being equal; as not only did the exudation in the larynx not increase, but the surrounding congestion was relieved, the glottic spasm overcome, sleep of a gratifying character secured (a matter of no small importance in laryngeal diphtheria), and a bountiful supply of vitalizing oxygen afforded, and a good recovery the result.

In the spring of 1881, a child of 4 years was referred to me, with extensive warty growths of both vocal bands. After attempting a variety of treatment, tracheotomy became necessary, and was performed, with the valuable assistance of my friend Dr. Shepherd. Local and constitutional improve ment followed. Seven months later I plugged the tube, and

found congestion increase, and subsequently the warty growths showing renewed activity. After three weeks I again removed the plug, the papillomata once more diminishing, until in Aug., 1882, the child, previously completely aphonic, had almost regained her natural voice.

In primary laryngeal cancer, one's experience is limited.

W. H., aged 68, referred by my friend Dr. Blackader for a laryngeal tumour rapidly developing, I diagnosed malignant disease of the right ventricular band. In a few days the breathing became so much embarrassed that I decided upon the immediate necessity of operative interference. Accordingly, with the assistance of Drs. Blackader, Browne and Shepherd, I tracheotomized. On subglottic examination, I found no extension below the floor. The man's condition materially improved, the acute shooting pains were relieved, and my patient expressed himself as highly gratified with the result. No extension of the tumour took place into the larynx; the thyroid isthmus and bodies showed induration three or four months afterwards, as also did the tissues in the neighbourhood of the wound. Post-mortem, extensive ulceration of the trachea was found. Death was due directly to cachexia, and was almost painless. Previous to the operation the man showed marked delirium. The operation relieved this. The arrest of the growth and the prolongation of life, I do not hesitate to say, were due directly to the rest secured by the operation.

The second case, now living, was Mrs. D., aged 60, referred by Dr. Lapthorn Smith. In this case an early diagnosis was made. The tumour occupied the posterior half of the left ventricular band and arytenoid, and was under observation for five weeks previous to operating, during which time Dr. Smith continued the use of astringent and sedative applications, and administered, on my advice, iodide of potassium liberally. No improvement resulted, and tracheotomy became a necessity. On the 4th of May, 1882, I assisted Dr. Smith to operate. I have frequently seen the patient since (and although no ultimate good can result, her friends at least will be saved the pain of seeing their relative succumb amid the writhings of strangulation), and

find there has been a marked diminution in the tumour, a comparative freedom from cough and pain, an improvement in deglutition, to say nothing of the improvement in the general health.

That improvement should follow rest in cancerous disease of the larynx is not to be wondered at, when we remember that in malignant disease of the rectum, the operation of colotomy is frequently followed by marked improvement.

While on the subject of laryngeal cancer, I will briefly refer to a point which further experience may yet develop into one of diagnostic value. Under the anterior border of the middle-third of the sterno-mastoid muscle of the same side on which malignant disease exists will be found a mass of indurated glands of from 2 to 2½ inches in length, and of the thickness of the middle finger. This condition I have not observed in tubercular, syphilitic, or chondrial disease, nor in cases of œsophageal disease involving the lower pharynx, and I desire here to record it.

In tubercular disease, tracheotomy has been resorted to when swelling threatened death by asphyxia. A middle-aged female following my clinic for considerably more than three years, with tubercular disease, was admitted into the wards of the hospital with an acute pleurisy, the result of exposure. After a few weeks she was referred to me for laryngoscopic examination. I found a tubercular condition, with great swelling, and reported the necessity of an immediate tracheotomy. On the same evening, Dr. Bell, the medical superintendent, was hastily summoned and found it necessary, in the emergency, to open the air passage with an ordinary penknife. Resorting to artificial respiration, he succeeded in reviving the patient. Some eight or ten months have elapsed, the tube is still worn, the laryngeal condition is improved, and the disease in the lung apparently arrested.

Though tracheotomy, or rather the rest it secures, does not offer much hope of ultimate recovery in these cases, it sometimes stays disease by removing at least some of the exciting causes, it relieves the diseased laryngeal structures from contact with the irritating air, lessens cough, and affords perfect rest, ulcerations heal, swellings diminish, and comfort is secured. In injuries to the larynx from scalding water, steam, or destructive

agents, rest will accomplish in a few days what would otherwise take weeks. Comparative physiological rest may also be obtained by the local use of sedative and astringent applications. Nitrate of silver affords a striking example of this, forming an albuminate or chloride, thus protecting the ulcerated surface from irritating contact, thereby lessening the recurrent spasm of the vocal bands and irregular contractions of the intrinsic muscles, as the mucous membrane and the intrinsic laryngeal muscles are supplied alike by the pneumogastric nerve. The physiological rest secured by the silver application makes itself often felt in the complete recovery from morbid states. The influence of rest may be further exemplified by the fact that where a tracheotomy has had to be performed for breathing purposes, ulcerations that had previously obstinately refused to yield, rapidly take up healthy action under the same medicinal agents to which they had previously refused to surrender. In spasms of the glottis of an obscure nature, tracheotomy frequently affords relief by the rest it secures when the tube is worn for a sufficiently long time. When it is necessary to continue the use of a tube over several months, or longer, I would suggest the use of gold for the outer tube, preferably to any other metal. Gold will be found much less irritating to the wound and much cleaner, opposing, as it does, the chemical action of mucus, bronchial and traumatic secretions. A lighter tube, also, will be equal in strength to a much more heavy one of silver, and the cost will not be more than double. I am not aware of the use of gold having been previously recommended, and take this opportunity to do so, with confidence as to the result. In hysterical aphonia (so-called), rest, if enforced, can work wonders. I can call to mind, at least three cases, where rest from all attempts at phonation gave good and rapid results after medicinal dosing and all manner of treatment, threats and entreaties not excepted, had proved an ignominious failure. I advanced the theory some two years ago that this condition was the result (among other causes) of the attempt to phonate on inspiration instead of expiration ; that this was the result of a faulty habit, and could only be rectified by observing absolute rest of voice, unless when undergoing a daily course of vocal

gymnastics, the laryngeal mirror being held in position; and that thus the action of the bands might be observed, and a suitable course of instruction adopted.

CLINICAL NOTE ON HÆMATEMESIS IN CHRONIC SPLENIC TUMOUR.

By WM. OSLER, M.D., M.R.C.P., Lond.

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Hæmorrhages are very common in all forms of chronic enlargement of the spleen, more particularly in that accompanying leucocythemia. A depraved blood condition would appear to be the main factor, as we meet with them in profound anæmias, not splenic in origin. Epistaxis is the most frequent, and next hæmorrhage from the bowels; hæmatemesis, hæmoptysis and hæmaturia are occasionally met with. Of 150 cases of leucocythemia collected by Gowers, hæmorrhages occurred in 80, and 8 of these from the stomach.

The point to which I wish to call attention, and which is illustrated by the cases, is the occurrence in some instance of severe, perhaps fatal, hæmatemesis at an early stage of the splenic trouble, even before the constitutional symptoms are marked. Indeed it may be the first symptom for which the patient seeks assistance, or, proving fatal, the only one, and the nature of the affection is entirely overlooked. The importance of the fact is chiefly from the diagnostic standpoint, and in an attack of vomiting of blood, the attention should always be directed to the spleen, as well as to the liver, as a possible cause. The cases are as follows:—

Case I.—J. H., aged 36, admitted to Hospital on Sept. 2nd, 1879, with anæmia. Served seven years in the army in India, and had intermittent fever. Has been a healthy and temperate man. Since his discharge from the army, has lived in Canada, and has enjoyed good health. In January, 1879, he had an attack of vomiting blood, which was preceded by a slight indisposition, a feeling of weight about the abdomen, and nausea. The bleeding occurred three times in a week, and on each occa-

sion he lost a large amount, and was much reduced. His strength returned slowly, and he resumed work. In July, the bleeding recurred—a single, large hæmorrhage. In January, '79, he noticed that the abdomen was a little prominent, particularly in the upper part. Later on it was not so evident, but he began to feel weak, lost his colour, and was not able to work. In July he had a severe attack of diarrhœa, and, shortly after, another hæmorrhage. For the two months before admission, the belly increased considerably. When he came under observation, there was marked anæmia, abdominal distension, and œdema of the ankles. The spleen was considerably enlarged ; dulness extended from lower border of 8th rib, a distance of $7\frac{1}{2}$ inches in the axillary line. It could be felt ; it was felt as a distinct tumour emerging beneath the left ribs, and extended to the navel, and when he stood up, the lower edge reached two inches below this point. It was not painful. There was some fluid in the peritoneum. The blood was thin and watery, and, microscopically, presented the characters of anæmia. The red corpuscles were greatly reduced, under two millions to the cubic millimetre, and the hæmoglobin was correspondingly diminished. There was no leukæmia. The heart's action was always a little excited ; pulse about 100 ; hæmic murmurs present. Sweats were troublesome. He remained in hospital a month, taking iron with benefit ; the œdema of the ankles disappeared, and the belly diminished in size. He had no hæmorrhage. He was taken to Glengarry by his friends, and I heard from his sister that he died some weeks after from the effects of a severe hæmatemesis.

Case II.—On the 13th of August, of this year, I was consulted by Mrs. ——, from Kingston, who brought her little girl, aged 11, for examination. She gave the following history :—

Nothing special in family ; one child had died of phthisis. This one had been healthy ; but two years ago, after a slight indisposition, she had a severe attack of hæmatemesis, lasting over twelve hours, during which time she vomited a basinful of blood. She had some pain in the abdomen, which also appeared swollen. Four years ago she was not well, and the mother thinks that then there was vomiting of blood-tinged matter, but

this is doubtful. She recovered from the bleeding in 1880, and seemed to thrive like the other children, though paler. In July last, just a month ago, a brother died, and the excitement at the time brought on another attack, which lasted 36 hours, and she lost nearly three quarts of blood. She picked up rapidly, and from her general apprarance I could scarcely credit that she had lost so much blood only a few weeks previous. She was a well-nourished, stout girl, but the face was pale, and a puffy look about the eyes. She complained of an uneasy feeling and fullness in the stomach. The feet swell in the evenings, and she is short of breath when walking fast or going up stairs. Lately her appetite has failed.

On examination, nothing abnormal was detected in heart or lungs; sounds clear, no murmur. Abdomen a little distended; panniculus adiposus thick; palpation revealed a splenic tumour in the left hypochondrium, extending three inches below the costal border, and to within an inch of the navel; the edge was clearly felt. It was not painful. The liver was not enlarged; no distension of abdominal veins; no signs of ascites. Blood thin; corpuscles normal as regards size and general appearance; no special increase of the colourless elements. Red per cubic mill., 2¼ millions; ratio of white to red, 1 to 316.

Dr. Howard has kindly permitted me to refer to the following cases, which illustrate the same point. In both I performed the autopsy:—

Case I.—A plump, well-nourished lad, aged 13, had, on April 12, an attack of vomiting of blood, and shortly after had a large bloody stool. Four years before, he had been unwell, and passed blood from the bowels and was pale. On the day before the attack he had played "lacrosse," and seemed in fair health. The spleen was found to be enlarged, extending a hand's-breadth below the costal border, and the blood was leukæmic. The vomiting recurred, and he lost altogether about four pints. On the fourth day, he died from the effects of the repeated hæmorrhages. At the autopsy, spleen found much enlarged; weighed 480 grms. No erosion or ulceration of the stomach; mucous membrane pale.

Case II.—A young lady, aged —, daughter of an American physician, studying French in the city, was suddenly attacked with violent hæmatemesis, which proved fatal in 24 hours. She had been in apparently good health, was well-nourished, and neither she nor her friends suspected any disease. At the autopsy, the spleen was found enlarged and firm, and the blood in the portal vein was markedly leukæmic. A peculiar malformation was met with in the portal vein, which presented a double trunk.

QUARTERLY RETROSPECT OF SURGERY.

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Bone-Setting (so-called).—What is generally known by the above name, but which is more properly called "Forcible Extension or Movement in Stiff Joints," was the subject of two papers at the last meeting of the British Medical Association. The first paper was by Mr. Howard Marsh, F.R.C.S., and the second by Mr. William Adams, F.R.C.S.

Mr. Marsh (*Brit. Med. Journal*, October 7th, 1882) remarks that the value of manipulation in the treatment of stiff joints has of late years been attracting increased attention because it has been the fashion for many of the public to place themselves in the hands of bone-setters, and that no doubt some people are much benefitted whilst others are injured. Mr. Marsh says bone-setters are a very miscellaneous group, who resemble each other mainly in the negative point, that they are completely ignorant of Anatomy, Pathology, or Surgery. Some are blacksmiths, others are shepherds. They stand in the same relation to Surgery as herbalists do to Medicine, and have existed in the remote districts of England from time immemorial. Again, we have bone-setters residing in towns who equip themselves with the names of the principal bones and muscles, hang up a skeleton in the consulting room to show patients exactly what is wrong, &c. This class employs anaesthetics freely, making

use of daily passive movements, rubbing and shampooing, and in spinal cases they often put on a Sayre's plaster jacket. In every case the bone-setter asserts that a bone is out and that he can put it in. A patient who consults a bone-setter is merely playing a game of hazard. His fate depends on what is the matter with him. If he has a stiff ankle after a sprain, he will very likely be cured; if he has a strumous joint, he will be more or less injured, while if he has a bunion or node on his tibia, he will find himself neither better nor worse. Mr. Marsh then goes on to relate a number of cases which were injured by going to bone-setters, especially patients suffering from tumours of bone. "But," he asks, "how is it that bone-setters sometimes succeed, where surgeons have failed"? and answers, "There is a considerable number of minor ailments of and around joints, that interfere with free movement or produce pain, such as adhesions, slipped tendons, hysterical affections, rigidity of muscles, &c. These conditions . . . . have one point in common, that they may be cured by free movement." Bone-setting consists in the process of carrying the affected joint through its full natural range of movement in all directions, and especially in that direction where there is most resistance. If the knee is flexed it has to go straight, &c. In the majority of cases really little force is used, for an anæsthetic is often employed. Then, again, bone-setters acquire by practice much facility in handling and moving joints, they know how to seize a limb at an advantage, and where no anæsthetic is given, they take care to divert the patient's attention, so as to take the muscles off their guard. In most cases, very moderate force is needed to break down adhesions, and the less the force required to remove the impediment to motion the more sure the case. This fact might be clearly set before medical men, so that in future they will have less fear of doing injury by manipulation.

Manipulation is chiefly useful when healthy joints have their movements restricted by external adhesions or by rigidity of muscles, slipped tendons, &c. Joints after sprains, dislocations or fractures should not be too long fixed by splints and bandages. When joints are seriously diseased, manipulation will generally

do harm, and in cases of firm fibrous ankylosis, the restoration of movement is quite unlikely. The position of the limb may however be improved.

Joints that are fit for manipulation are those which, after injury, are cool and free from much synovial swelling, &c. Mere pain, if there is no heat in the joint, by no means forbids manipulation, on the contrary, it is a strong reason for using it. In certain cases where the diagnosis is obscure, but where there is no evidence of structural disease though the joint is stiff and disabled, manipulation under an anæsthetic often effects a cure. Some of these cases are hysterical, some are deep-seated adhesions, some slipped tendons, and some simple muscular rigidity. Manipulation must be supplemented by passive motion. Mr. Marsh ends his interesting paper by referring to the importance of attending carefully to the minor affections about the joints. By being remiss in these cases we open the door to bone-setting and we are apt to commit oversights that we cannot fail to regret.

Mr. William Adams in his paper (*British Medical Journal*, October 7th, 1882), strongly advocates the use of "Forcible Movement" in Stiff Joints. He arranges stiff joints as follows:

(1) Cases of traumatic origin in healthy constitutions, generally occurring in the adult.

(2) Cases after rheumatic inflammation of the joint.

(3) Cases after strumous disease of the joint.

(4) Cases of acute suppurative inflammation of pyæmic origin; and suppurative inflammation in the neighbourhood of, and extending to, the joint.

(5) Cases consequent on muscular contractions.

The first class of cases, as a rule, are favourable for treatment by forcible extension, and include stiff joints after dislocations, and fractures into joints or in their neighborhood, also stiffness following bruises and inflammation of joints.

Cases of the second class are also, as a rule, favourable ones for this treatment, whether the rheumatic affection be acute, chronic or gonorrhœal.

Classes 3, 4 and 5, Mr. Adams considers, are essentially

unfit for this method of treatment. In the last class, where stiffness is due to muscular contraction, forcible extension is injurious. They should be treated by tenotomy and gradual mechanical extension.

Mr. Adams deprecates violent extension, and says he has seen many accidents, such as fracture of bones, rupture of arteries, &c., follow its use. His method of procedure is as follows. In severe cases at the first operation, he uses only sufficient force to attain the least possible movement, then at successive operations, repeated at intervals of two or three weeks, he tears through the other adhesions and gradually increases the range of movement till the full extent is obtained; after each operation he applies hot water dressing, generally using spongiopiline and in the leg always makes use of weight extension. Absolute rest is essential, and in some cases he uses the local vapour bath two or three times a day. In simpler cases, a single operation will often suffice, but it is frequently necessary to repeat it three or four times.

Sir James Paget, in a Clinical lecture delivered in 1867, was the first to treat of the cases that bone-setters cure. This he did in his usual masterly manner; the lecture is published among his "Clinical Lectures and Essays." Among the affections of joints cured by bone-setters he enumerates, slipped tendons, locking of joints, especially the knee, injured joints held stiff by involuntary muscular action, stiff joints following sprains, and hysterical joints. He says, in the treatment of these affections we can learn to imitate much that is good in practice of the bone-setters. Dr. Wharton Hood in 1871 published a valuable little book on bone-setting. That bone-setters fail frequently to do any good and very often do great harm, is no doubt true, but with charlatans one success covers a multitude of failures. The victims of the bone-setter's skill rarely say much about their injuries. In many cases, indeed, the operator before commencing treatment demands written guarantees from the patient. Thus we only hear of the successful cases, the disasters being carefully concealed. There is an Italian woman in New York who has an immense bone-setting practice, and I know of several

cases that have gone to her, even from this city. Most of them being cases of hip disease were of course not benefitted, but all were guaranteed a cure, and some hysterical spines she certainly benefited. These cases, however, would be quite as successfully treated by prayer, mesmerism, or other extraordinary method. The regular practitioner is often to blame for manufacturing cases for charlatans to cure, as when after reduction of a dislocation the limb is kept too long at rest or manipulation is not practised after a Colles' fracture or a sprained ankle is kept up in plaster or starch for sometimes a month. No case of stiff joint due to ordinary fracture in neighborhood of joints or to the after effects of dislocation should be left to time to produce free movement. The surgeon should himself see the proper manipulations carried out and that the joint recovers its free range of movement. Bone-setters, in suitable cases, are less afraid of hurting the patient than is the ordinary practitioner, and although in many cases they do a great deal of harm, yet in many others their cures are very rapid, and to the public, marvellous. So the old adage is again proved true, that fools rush in where angels fear to tread.

Reduction of Dislocation of the Shoulder.—Every year new methods for reducing dislocation of the shoulder are brought out. M. Kocher, at the last International Congress (London *Lancet*, Nov. 4, 1882), read a valuable paper on this subject. In sub-coracoid dislocations, he asserts that the aim of the surgeon should be to open out the rent in the capsule and relax the parts of the capsule which are untorn but put on the stretch by the altered position of the head of the humerus. The rent in the capsule is on the inner side the most tense part, where it is thickened by the coraco-humeral band. The lower part of the capsule is also tense. Kocher asserts that by rotating the arm outwards, the top of the capsule is itself rotated out and the rent rendered patent: if now the arm be advanced in the vertical median plane, the upper part of the capsule is relaxed and, the head of the bone, being prevented passing forwards by the lower fibres of the capsule, enters the glenoid fossa. The following is his method of procedure. The patient should be seated,

with the surgeon on his left hand. The elbow joint is first to be flexed at a right angle, and the elbow firmly pressed against the side of the chest; then, while holding the elbow in contact with the body, the arm is to be slowly, gently and steadily rotated out until firm resistance is encountered; then maintaining this rotation the arm is to be raised forwards and a little in, and lastly to be rotated in and the hand brought to the opposite shoulder. It is stated that there is no need for anæsthetics when this manipulation is employed. M. Ceppi says this method is most valuable in old dislocations, they can be reduced without force and without anæsthetics. M. Kocher has succeeded in twelve cases of dislocations, varying from three weeks to four months old. In one case where the bone had been displaced for eight weeks, he fractured the shaft of the humerus in attempting reduction, and six weeks later, when the bone was united, failed again. This patient was seventy years of age.

This is certainly a very simple method of reducing dislocations of the shoulder, and is well worthy of a trial by surgeons. The fact that anæsthetics may be dispensed with is much in its favour, as in no operation have they, especially chloroform, been so fatal (why it is not known), as when used to cause muscular relaxation for the reduction of dislocations of the shoulder. The method much resembles that employed now almost universally for dislocated hips and is based on the same principles. Lately, I have used Sir Astley Cooper's method of operating with knee in axilla, with success, when I did not wish to give an anæsthetic.

Mr. James E. Kelly, F.R.C.S. Ireland, has lately advocated a method of reducing dislocations of the humerus (Dublin *Jour. Med. Science*, Sept. 1882), which in his hands has proved most successful. It is as follows: First the patient should be placed on a firmly fixed hard couch, which ought to be about three inches lower than the great trochanter of the operator. The patient should be placed as close as possible to the edge of the couch, on his back with his head low. The operator then places the injured arm at right angles to the body and standing against it, with his side to the patient and his hip placed firmly, but not

roughly, into the axilla, he folds the arm and hand of his patient closely round his pelvis and fixes the hand firmly by pressing it against the crest of his ilium; then the operator (with the patient's arm round his pelvis and his hip pressed into the axilla) turns himself rapidly so that his back is against the side of the couch. Mr. Kelly says one of the greatest advantages of this operation (which is more intelligible when the illustrations are seen) is the ease with which a surgeon can rednce almost any dislocation without assistance or anæsthetics. The scapula is fixed by being between the couch and the patient's body. This method appears very simple and easy of performance. The difficulty of having the proper couch always at hand would sometimes interfere with its employment.

Mr. Kelly has also employed a similar method for reducing dislocation of the hip, a full description of which may be found in the Dublin *Journal of Medical Science* for October, 1882. In the *Canadian Journal of Medical Science* for December, a writer describes a case of dislocation of the shoulder, in which Kocher's method signally failed, but Kelly's plan was entirely successful.

Radical Cure of Hernia.—The question of the most suitable operation for the radical cure of Hernia is still unsettled. Most of the operations are more successful in the hands of the originators than of any other, and no method has fulfilled the promises which accompanied its announcement to the profession. One method which according to report was always successful, is that practiced secretly by the late Dr. Heaton of Boston. Before his death he gave his method to the world in a little book published in 1877, and edited by Dr. Davenport. Dr. Heaton had for years treated herniæ by injecting solution of oak bark into the hernial ring to arouse sufficient inflammatory exudation to close the rings and then applying a peculiar bandage. Ten days rest in bed was all that was required. He also, in irreducible herniæ, made them reducible by daily manipulating the tumour and thus breaking down the adhesions. According to his book he often made these cases reducible in two or three days and then injected his fluid. Other cases of omental herniæ again he cut down upon and removed a portion, broke down the

adhesions between the sac and omentum, and returned the mass into abdomen. Mr. Heaton never had a fatal case during the whole period of his practice which was over 30 years. Surgeons, however, who have adopted his method have had but fair success with it. In the *New York Medical Record* for Nov. 11th, is an article by Dr. Wm. T. Bull of New York on Heaton's operation. He has performed the operation 49 times on 40 patients without any serious disturbance, but only in twenty-one can he report the ultimate result, the remaining nineteen have not been seen since leaving the hospital; of the twenty-one cases traced, five have been cured, seven improved, four temporarily improved, and five have not been improved at all. With one exception, all the operations were for inguinal hernia. Dr. Geo. W. Gay of Boston has operated twenty-three times, with the result of four cured, eight relieved, and three unrelieved.

At the end of his paper, Dr. Bull quotes and endorses Dr. Gay's general conclusions as to this operation, "I know nothing of the merits of the operation in other kinds of hernia, but in the one under consideration (inguinal), I can but conclude that it is safe. It is not very painful, it is not very difficult to perform, it does little harm even if it does no good. It will cure a certain number of cases and relieve others." Dr. Bull from his experience feels justified in recommending the operation, and he is sure that in another series of twenty cases he could greatly improve his record—and he hopes that his report of the operation will incite the profession at large to study its advantages.

Dr. Bull, who is a very able and skillful surgeon, deserves great credit for the way he has recorded his cases, although his success has not been so great as others, as, for instance, Dr. Joseph H. Warren, who *now* asserts he never has a failure, in his first series of cases he had *some* failures which he considered due to "imperfect instrument and crude injecting fluid," or Dr. H. S. Greene, of Kansas City, Mo., who had 91 cures out of 97 operations. It is certain that Dr. Bull's statistics are perfectly to be relied upon. Enthusiasts in any operation or mode of cure are very apt to look through rose-colored glasses and see cures where an impartial observer, such

as Dr. Bull, would only see improvement. Perhaps one reason Dr. Bull had not a greater proportion of cures is that he was satisfied with both Heaton's instrument and fluid, and did not invent a new instrument or a more effective injecting fluid!! This method of treating hernia by injecting the sac is an old one having been first introduced by Velpeau. Another of the recent operations for the radical cure of hernia, is that of Mr. William Dunnett Spanton. Mr. Spanton first described his operation at the meeting of the British Medical Association of 1879; since then he has contributed various papers to the Medical Journals narrating cases and describing his operation. The operation is performed with an instrument something like a cork screw, but with a flat point, so as to pass through the fibrous structures, without doing much violence to them; it is broader near the point than at the handle, so that as it is screwed onwards into the boundaries of the canal it approximates them to each other. The same preparation of the patient is made as for Wood's operation, by shaving the skin, incising it, and separating it from the subcutaneous tissue to such an extent as may be necessary to permit the invagination of the latter. The rupture having been reduced, the left forefinger is passed into the scrotal wound, pushing before it sac and scrotal fascia high up into the inguinal canal, so that the finger can easily make out the condition of the abdominal rings and the surrounding structures. The invaginated tissues being so held by the finger, the spermatic cord being protected by the finger, the point of the screw is, with the right hand thrust through the skin of the groin, so as to pass through the conjoined tendon at the internal ring in such a way, that the point comes against the tip of the left finger. The screw is next made to transfix the sac and fascia held in the inguinal canal, so as to pass across to the external pillar subcutaneously, a turn is then given to the screw so as to push it through the internal pillar of the external ring and again across to Poupart's ligament, the point emerging through the scrotal fascia at the wound, thus the sides of the hernial canal are approximated throughout, and the plug of invaginated tissue is firmly held in position while consolidation

is taking place. The handle of the screw then lies flat on the abdomen, the point is protected by a ball of india-rubber, and the scrotal wound closed by a suture of catgut, there is no hemorrhage. The screw is removed in the the 9th day, dressings relinquished in about two weeks, and at the end of a month the patient is allowed to get up, the parts being firmly consolidated. In sixty cases in which Mr. Spanton has operated (*Annals of Anatomy and Surgery, Oct.* 1882) all are now living, and in a large proportion of them a permanent and satisfactory cure has been affected, while in others the patients are so much improved that some who could not wear an effectual truss are now able to do so quite comfortably. In a small proportion the result has been almost nugatory. If a continuous ligature is preferred, the screw with a large eye at the point is passed in the manner described above, then threaded with a ligature when the point appears through the scrotal opening, and the screw gradually withdrawn upwards, the ligature following its track and occupying its place. In order to keep the ligature tight each end is fastened to a glass rod which lies in the groin until the parts are consolidated (in ten to fourteen days usually) the ends are cut off and the ligature remains. When this method of ligature is used operating under carbolic spray is desirable; but with the screw Mr. Spanton does not use the spray. The most satisfactory cases are those of congenital herniæ in the young, and the operation, says Mr. Spanton, is especially adapted for those cases in which the hernial aperture is large and the sac bulky, or when the congenital rupture is of old standing. This operation, which is a modification of Wood's and Wutzer's, is, according to the author, much less dangerous. All the cases operated on were of the inguinal kind. Mr. Spanton thinks that the wide-spread prejudice which prevails both amongst the profession and the public against operative interference in all cases of hernia, except when strangulated, is being rapidly overcome under the new era of antiseptic surgery. Many surgeons now cut down on the hernial tumor, reduce it and pass catgut ligatures through the pillars of the ring, so as to bring them together. By this method, Dr. H. O. Marcy

of Boston, Mr. Mitchell Banks of Liverpool, and others have had considerable success. Mr. Banks, at the last meeting of the British Medical Association, reported 30 cases in which he had cut off the sac and stitched the pillars of the ring together. There was no fatal case and only two failures, fifteen cases were completely cured, and did not require a truss. Dr. P. Kraske of Halle reports, in the *Centralblatt fur Chirurgie*, No. 26, 1882, two cases of congenital scrotal hernia, in which Prof. Volkmann operated for radical cure. He remarks that the operation of exposing the pillars of the external abdominal ring, scraping their edges and bringing them together with catgut ligatures is only applicable to cases where the hernia is reducible, or in cases of irreducible hernia in which the obstruction is situated in the neck of the sac. The hernial sac itself must be destroyed to make a complete cure. If the sac can be isolated it may be ligatured, but as the sac in congenital hernia also forms the tunica vaginalis, its complete removal is out of the question. Volkmann's practice in these cases is as follows: 1, If the neck of the sac can be isolated, a ligature may be placed around it, the pillars of the ring brought together by sutures, and the interior of the sac washed out and drained. Simple transverse section of the sac or partial excision should be practised. 2, If the sac cannot be isolated, it should be treated with Wahl's suture or plugged with a stump of omentum, and then the sac should be washed out and drained. In old patients one should consider the advisability of castration. 3, Where there is incomplete descent of the testicle, if the sac can be isolated, it should be cut off. If it cannot be isolated, then castration should be performed.—(*Abstract from London Med. Record*, Aug. 1882.)

Removal of Portion of Intestines.—Dr. Wm. Fuller (late of Montreal, and now of Grand Falls, Michigan), reports in the *New York Medical Record* of Oct. 14th, 1882, several cases of the above. The first case was of strangulated femoral hernia in a woman, where on cutting down, the knuckle of intestine was found to be gangrenous. The intestine was divided a little beyond each extremity of the slough, and a double linen ligature

was placed around the mesentery. The mesentary was divided beyond the ligature, and with it five and a half inches of the bowel removed. The two cut ends of the intestine were brought together by a continuous ligature of carbolized shoemaker's thread. The ends of the thread were cut off and the bowel returned to the abdomen. The sac was cut off and a drainage tube placed in the wound. The dressing consisted of flannel cloth wrung out of hot water and applied over wound and lower part of abdomen; this was frequently changed. Immediately after operation vomiting ceased and the general condition improved. On the fourth day she had a natural stool. Thenceforth her recovery was uninterrupted, and in six weeks she was about doing house-work.

Another case is also reported where four inches of intestine were removed from a child for invagination. The invaginated portion was felt through the rectum, it was drawn out and cut off and then returned. The child recovered.

A third case is related where omentum was cut off and the bowel returned in an operation for strangulated femoral hernia. Next day flatus was passed through the wound and a drainage tube was inserted. Patient had a natural stool on eighth day, and afterwards her recovery was uninterrupted.

M. Roser (*Centralblatt fur Chirurgie*) reports a case of resection of the intestine for acute femoral hernia in a female where death took place in 48 hours with all the symptoms of ileus. The autopsy disclosed the presence of a valve-like narrowing at the sutured spot; the gut below the suture was quite empty. On further examination it was seen that a swelling of a fold of the mucous membrane of the jejunum in combination with the sutured inversion of the edges of the wound in the gut, had produced the obstruction in question. This was attributed to a double row of ligatures which he had employed, eight internal and six external. These Roser thinks should not be employed in suture of the jejunum, but to obtain complete inversion of the serous membrane, he would advise that the lower mucous fold of the jejunum (which in transverse section usually becomes everted) be dissected off circularly in front of the stitch.—(*Edin. Med. Journal*, May, 1882.)

Credé of Dresden (*Deutsche Med. Wochen*, June 10th, 1882) reports a case of successful extirpation of the spleen for *cystic degeneration*. Patient was a male aged 24. Spleen removed through an abdominal incision. In 17 months patient left perfectly well. During convalescence no increase of size in the lymphatic glands could be detected, nor was there any disturbance in the marrow of the bones, but an inflammatory swelling of the thyroid gland occurred during the fourth month.—(*American Journal of the Medical Sciences*, Oct., 1882·)

Treatment of Tonsillitis.—Dr. Edward Mackey (*British Medical Journal*, Oct. 14th, 1882) thinks the treatment of tonsillitis by the salicylates is not so widely recognized as it should be. The value of this treatment was first pointed out by Mr. Hormazdji. He recommended twenty grain doses of the salicylate of soda. Dr. Mackey gives it in ten grain doses every two or three hours. In all the cases treated the pyrexia was much lessened and great relief experienced by the patient almost immediately after taking the remedy. Dr. Mackey also recommends a lotion of two drachms of salicylate of soda to eight ounces of water as a very efficient remedy for the severe pain of gouty joints.

Dr. E. Staver (*Phil. Med. News*, Nov. 18th, 1882) recommends the application of powdered bicarbonate of soda to the inflamed tonsils by means of an insufflator. The fever rapidly declines and with it the discomfort.

Dr. Henry describes (*New England Medical Monthly* for June) a number of cases of hypertrophy and ulceration of the tonsils which he has cured by the use of iodoform in the form of spray. He dissolves the iodoform in strong sulphuric ether. This he sprays on the tonsils by means of a spray producer of his own, having three tubes, one turned down, one straight and the other turned up. The posterior part of the tonsils is sprayed with the turned down tube.—(*London Medical Record.*)

Dr. Fraenkel (*Verhadl. der Berlin. Med. Gesellsch.*, Bd. xiii., p. 129), says *Catarrhal Angina* or *Tonsillitis Lacunaris* in the great majority of cases, subsides without treatment, so that our object can only be to shorten or render it less severe. The use of astringents, such as nitrate of silver, he considers

useless, as the disease lies mainly in the crypts of the tonsils, which the astringent does not reach. The same is true of gargles and of inhalations, while the former, in addition, frequently themselves cause unpleasant sensations in the throat. The use of emollients gives frequently much relief. Dr. Fraenkel has tried submucous injections of a carbolic acid solution, so as to be sure of reaching the crypts, but has seen no benefit from them, neither has he seen any good results from chlorate of potash, which is so often useful in stomatitis. Of guiacum, recommended strongly by Dr. Morell McKenzie, he has had no experience, nor has he had any experience of tincture of aconite, which last remedy he thinks has been borrowed from homœopathic sources by English physicians. Ice and cold applications are to many most grateful, while to others they are absolutely intolerable. For some months he has treated all his cases with quinine or salicylate of soda. Of 15 cases treated with large doses of quinine, not one has lasted longer than 48 hours, the usual average being two to five days. He gives three doses of about 4 grains of quinine within an hour at night. Although quinine shortens the disease, it does not in certain cases prevent peritonsillar abcess. The *rationale* of the action of quinine, Dr. Fraenkel does not pretend to understand.—(*London Medical Record*, Oct., 1882.)

Mr. Kenneth Millican (*London Lancet*, July, 1882) agrees with Dr. Atkinson's statement that *Tonsillitis* generally depends on two causes, great mental anxiety and irregular meals. Dr. Atkinson does not believe (*Lancet*, August 26th) that Acute Tonsillitis is the direct result of cold, but he has often found it associated with masturbation.

I have myself noticed that Acute Tonsillitis is occasionally seen in the newly married, and is connected in some way with sexual excitement. During the last two years I have had four cases of severe Acute Tonsillitis in newly married women and two cases in newly married men. Probably this cause would come under the head of Anxiety. There is perhaps, after all, truth in the old theory that there is some connection between the tonsils and the generative system.

The treatment I have found most successful is the application of an ice poultice around the neck and the administration of minim doses of aconite every two hours. Lately I have had good success with salicylate of soda, it often cuts short the disease and nearly always alleviates it.

Dr. Gordon Holmes, in article in *London Lancet* for Nov. 11th, 1882, on the *Treatment of Enlarged Tonsils*, recommends excision with Fahnstock's Tonsillotome. He does not recommend the operation in the acute stage, as he says it is by no means uncommon to see even mild cases of subacute or chronic tonsillitis in which a considerable swelling undergoes spontaneous involution in the course of a month or two. Such instances are very apt to mislead the practitioner into the belief that a cure has been wrought by the aid of some really impotent local application. "It is also," he says, "interesting to observe that in a series of such attacks where the subsequent involution is always less and less complete, we can perceive the origin of chronic tonsillar hypertrophy." He dissents from the theory that the removal of the tonsils has some adverse effect on the generative system.

If excision is objected to by the patient or his relatives, he recommends repeated cauterizations of the enlarged tonsils by the solid nitrate of silver or chloride of zinc. Thin pointed sticks of these should be pressed into the lacunæ, or orifices of the follicles, which are easily seen and are of large size in a hypertrophied gland. In this way we can attack the heart of the gland in a most efficacious manner. Small sloughs form, which are soon discharged and thus the tonsils are hollowed out in one direction while being contracted by subsequent cicatrization in another. Two or three channels in each tonsil can be cauterized daily or on alternate days, and thus a comparatively large surface can be acted on with very little suffering to the patient.

(To be continued.)

BI-MONTHLY RETROSPECT OF OBSTETRICS AND GYNÆCOLOGY.

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Extra-Uterine Pregnancy.—At the last meeting (in September,) of the American Gynecological Society, Dr. T. Gaillard Thomas read a paper entitled, "Notes on Twenty-one Cases of Extra-Uterine Pregnancy." The author began by saying that until the last decade very little attention has been paid to the clinical study of extra-uterine pregnancy. In a general way it has received attention in works upon obstetrics, and the physiology and pathology of the subject have been carefully investigated, but its clinical bearings and collection of histories, and the careful collation and analysis of the symptoms which should arouse the fear and suspicion of the practitioner, and give the most appropriate treatment, had received an amount of attention entirely incommensurate with their paramount importance.

For the pathologist there were many varieties, but for the practitioner there are naturally but three, namely, tubal, interstitial, and abdominal. The history of twenty-one cases which had fallen under his observation was then briefly given. The symptoms which most frequently led to diagnosis were the symptoms of normal pregnancy accompanied by: 1st, regular gushes of blood ceasing and suddenly recurring without assignable cause; 2nd, fixed grinding pain in one iliac fossa, and perhaps down the corresponding thigh; 3rd, paroxysmal pains occurring with severity, marked by constitutional symptoms and in a short time passing off, to recur with increased violence in a few days; 4th, symptoms of abortion without an appearance of the fœtus; 5th, expulsion of membranes without accompanying fœtus.

The physical signs which sustained the validity of these symptoms were: 1st, Increased size in the uterus and displacement of it upwards, forwards, and laterally; 2nd, evidence of vacuity in it, yielded by the sound or tube; 3rd, the presence either to

one side of the uterus or behind it of a cystic tumor somewhat painful to the touch, rather immovable, giving to palpation a sense of rather obsure fluctuation, and in some cases yielding the sign of "ballottement". In a few of his cases this sign has been plainly distinguishable, but this had been an exception to the rule, and the absence of it should never be relied upon as evidence against the existence of the condition. In cases of advanced gestation of the ectopic variety, the placental murmur, the fœtal heart, and the movements of the fœtus will of course present themselves as valuable signs; but in tubal pregnancy, the kind most commonly encountered, death will generally occur from rupture of the fœtal nest before they become at all available.

As to treatment, he proposed simply to give rules which he thought his experience would induce him to adopt in future.

First. If an ectopic tumor be discovered and its nature pretty well settled before the end of the fourth month of gestation, he would destroy the vitality of the child by electricity in preference to all other methods which have been proposed.

Second. Should the fourth month of gestation be passed and surgical interference be called for, laparotomy or, if the tumor be low down in the pelvis, elytrotomy should be preferred to the use of electricity, which leaves a large fœtal body to undergo absorption inside the body of the mother.

Third. Should the pregnancy be abdominal, the practitioner should wait and watch, if possible, until nature demonstrates the outlet by which she desires the extrusion to be effected, then she should be aided. If, on the other hand, bad symptoms, under these circumstances, at any time showed themselves, laparotomy under strict antiseptic precautions, should be promptly resorted to.

Fourth. Should rupture of the fœtal nidus have occurred before diagnosis has been fully made, the practitioner should wait and see whether nature is powerful enough to overcome the shock and control hemorrhage, then, further, if the patient is going to escape the dangers of peritonitis and septicæmia. If these favorable results do not occur, if hemorrhage is about to destroy the patient immediately, or if septicæmia attacks her

later, laparotomy, followed by antiseptic cleansing, should be promptly adopted.

Why is *Chloroform safer in Midwifery* than general practice? The fact is generally known, but we do not remember having seen until now a good reason adduced. The immunity from accident is not absolute. Dr. Lusk believes that it is due to greater caution in administration. He narrowly escaped losing a patient in Bellevue Hospital on whom he designed to perform version, in consequence of his house-physician suddenly crowding a paper funnel containing a towel wet with chloroform over the mouth and nose.—(*Am. Jour. of Obst.*, Oct, '82.)

Dr. Fancourt Barnes, in a note in the *British Medical Journal*, Oct. 21st, 1882, expresses his belief that the greater safety is due to the condition of the heart and vascular system during pregnancy. The heart becomes hypertrophied, the venous system becomes enlarged by the distension of existing veins and the development of fresh venules. The quantity of blood is increased. When chloroform produces fatal syncope, it does so by its depressing action on the heart. The weaker the heart, the more readily does it succumb to the paralyzing action of chloroform. The hypertrophied heart of pregnancy more readily withstands the action of chloroform. Mr. S. E. Burton, F.R.C.P., of the London Hospital, believes that another important factor comes into play in these cases—viz., the absence of the depressing, and even paralyzing influence of fear. In an ordinary operation, the patient approaches with dread; and nnmerous instances are on record in which fear alone has brought about fatal syncope, even before the further depressing effects of chloroform have had time to take effect—even before its administration has been begun. In confinements the case is different. The patient is already in great pain; the heart is acting powerfully, in consequence of great muscular exertion; and, instead of looking forward to the chloroform with dread as the antecedent to a dangerous operation, she actually desires it as a relief to present suffering. She is thus in the most favorable condition possible for its administration, and, even if there were no cardiac hypertrophy, we might expect an almost total immunity from fatalities from the use of chloroform in these cases.

A New Sign of Pregnancy.—Jorisenne, in an article in the *Archives de Tocologie*, June, 1882, indicates what he believes to be a valuable diagnostic sign for pregnancy during the first two months. We have hitherto had no unequivocal sign of early pregnancy. He has found that whilst in health there is a variation of from ten to twenty beats in the radial pulsation, according as the body is upright or horizontal, in pregnancy, no matter what the position, the beats number the same. The author has been able to diagnosticate pregnancy as early as the first month, when no other sign except the missing of the menstrual period was present. When examining a patient for this sign, it is necessary to proceed with deliberation, first counting the radial for the space of fifteen seconds whilst the patient is standing, then sitting, then reclining. The order may then be reversed, and uniformly the same number of beats will be recorded.

The Treatment of Placenta Prævia.—Hofmeier, assistant physician at the Berlin University Obstetrical Clinic, has an article on this subject in the *Zeitschrift f. Geb. u Gynäkologie*, Bd. VIII., Hft. 1. At the outset of his paper the author justly remarks that there is no obstetrical subject the literature of which is so rich as this. His conclusions and methods claim our attention on account of the excellence of his results. His material consisted of 46 cases, 35 of which were delivered in one year, thus offering an excellent chance to judge of a method carried out by one man in so many cases. In judging of his method, he first excluded from the 46 cases 3 who were so far gone from hemorrhage when he arrived that there was no chance for any treatment. Of the remaining 43, in 19 the location of the placenta was central, in 16 lateral, and in 8 marginal—a very large percentage of central. The usual rule of treatment is to tampon until the cervix is sufficiently dilated. *This* rule the author opposes. He scarcely ever uses a tampon, and as to the cervix, his rule is only to wait till clear symptoms of labour set in, either in uterine contractions or a funnel-shaped dilatation of the cervix. He then proceeds as actively and early as possible. This rule was followed in 37 of the 43 cases, after poor experience in other methods with the rest. In 19 the cervix was partially or wholly dilated; in 18, either entirely closed or with only a funnel-shaped

dilatation. The earlier the operation the more of necessity is the choice limited to the combined external and vaginal version with one or two fingers, the Wigand-Braxton-Hicks method. This was done in 30 cases, the foot was brought down in three breech cases, three times internal version was performed, and once the forceps applied. The combined turning was practised whenever possible, and the hand introduced into the uterus only when absolutely necessary. The feet having been guided to the os, are seized, and by firm traction the buttocks effectually stop the hemorrhage. In cases of central position of the placenta, the author, in spite of all the arguments against it, is in favour of perforating the placenta, and bringing the feet through. He did it in five cases, in three of which it was necessary on account of haste, and in two of which the child was already dead. It gives the mother the best chance, and the child's chance is by any method in such a case extremely small. The rest of the delivery, the author expressly stated, should be slowly accomplished. The condition of the child may modify this rule, but even this must not make us increase the mother's risk. One must have the courage to let a doubtful child's life be lost in his hands, rather than subject the mother to increased danger. The child is to be delivered slowly. Even so, the author's results were not bad as regards the children. Of 37, 17 were already dead; of the 20 still living, 6 died (3 premature and 3 from perforation of the placenta). Altogether, 63 per cent. died and 37 per cent. lived, which is up to the usual standard.

The statistics of the mothers, however, are very much better. The author considers in them not only the immediate result, but the aftercourse of the case. In each case ergotin was given subcutaneously during extraction, and the uterus washed out afterwards with a 5 per cent carbolic solution. Of the 37 patients treated by these rules, *one* died. She had been treated for 24 hours by tampon, and the placenta was foul and offensive when the delivery took place, and she died 17 days after from phlegmon and phlebitis of the thigh. He believes she would have surely been saved if action had been prompter. This one case out of 37 gives a mortality rate of 2.7 per cent., and 40 per cent. after-

hemorrhages occurred in some cases, but none which could not be controlled with ergotin, iced and hot water injections. Of the six cases treated at an earlier date, and by the *waiting* method, one died, and two had a long, severe lying-in; four children were dead. Of the whole 46 cases, therefore, 5 died; 10.8 per cent. The author adds two useful hints as to the location of the placenta. In nearly central location, the smaller portion is the one which is more loosened from the cervix lip. In placenta previa lateralis, the proportion in favour of the right side is about 11.4.

A Modified Procedure in the Operation of Cæsarean Section.—This is the title of an article in the *Archiv für Gynakologie*, Bd. xix., vol. 2; (an abstract of same in *Centralblatt fur Gynakologie*, No. 33, 1882.) In this paper the author, after referring to the various methods recommended in the performance of this operation, including Porro's method, states that the results of them all hitherto, notwithstanding the antiseptic system, are extremely unsatisfactory. He then formulated under three heads the objects required to render the operation as successful as possible: 1st, Section of the uterine muscle at the spot where it is least inclined to gape; 2nd, a reliable method of suture; 3rd, the strictest antiseptic measures during the operation, with removal and disinfection of the peritoneal exudations and of the lochia after the operation. To secure the first point, Kehrer recommends to make the incision transversely in the anterior circumference of the inner os, which is, on an average, a centimetre above the bottom of the vesico-uterine pouch. The tendency to gape is here very little, and it is further opposed in a powerful manner by the normal position of the ante-version after delivery during the childbed period.

In favor of this position for the incision, the author urges further that in this situation the placenta is rarely met with, whilst the head usually lies there, and thus early breathing of the fœtus is facilitated. In regard to sutures, Kehrer recommends the adoption of a double suture—one deep uniting the muscular wall, and one superficial to secure the co-aptation of the peritoneal surfaces. As to the third, the strictest antiseptic

arrangements are employed both before and during the operation. The vagina is thoroughly disinfected before the operation, the interior of the uterus is thoroughly irrigated by a carbolic solution and rubbed in with a carbolized sponge, whilst the peritoneal cavity is scrupulously cleansed. For maintaining subsequent drainage, Kehrer expresses himself in favor of several drainage tubes for the peritoneal cavity, but opposed to carrying a single drain through the abdominal wound, uterus and vagina. The drainage tubes should be so disposed that two small tubes should lie on the two sides of the vesico-uterine pouch, and a third larger, and longer, pass over the uterus into the pouch of Douglas. The paper ends with the records of two cases, one of which recovered, the child's life being saved also. In the second case the patient died. Both cases were for high deformity due to osteomalacia.

One thousand consecutive cases of Ovariotomy performed without any of the Listerian Details, by Mr. Lawson Tait.—This was the title of a paper read by Mr. Tait before the last meeting of the British Medical Association. There were only three deaths, one by accidental suffocation, it ought not therefore to be reckoned in the mortality of the operation. Six of the patients were pregnant at the time of operation. In one of these there was acute peritonitis at the time of the operation. All of these six pregnant patients recovered and had their children afterwards with one exception; she miscarried on the second day after operation and then made an easy recovery; four in all of the patients suffered from acute peritonitis at the time of operation. In two cases the disease was solid fibroma of the left ovary, in the other ninety-eight the disease was cystoma; of these the disease was in eleven cases parovarian, the ovaries and fallopian tubes were left intact, so that the operation was not ovariotomy at all. Mr. Tait has, however, included them, as Mr. Spencer Wells has done, and as everybody must do, who wishes to contrast with him. The proportion here given bears out Mr. Tait's previous estimate that parovarian cysts constitute about 10 per cent. of such operations. The presence of adhesions did not add in any way to the mortality. The operator attributes his remarkable success in this series of cases chiefly

to the abandonment of the clamp (Mr. Spencer Wells's) treatment of the pedicle; the adoption of Keith's and Kœberle's method of cleansing the peritoneum. Increased personal experience diminished proportion of cases that had been frequently tapped; complete abandonment of the use of carbolic acid, or any other so-called antiseptic system, in the performance of the operation, and in the subsequent treatment; the establishment of hospital discipline and hygiene, on the best known principles, for private as well as for public patients. Mr. Tait appends a table, giving the date of operation, the age, and residence of each patient, and the name of her ordinary medical attendant apparently with the object of preventing the making of unfair and unwarranted statements behind his back, statements no one was bold enough to make in public. Mr. Tait stated that in the instance of one well-known surgeon he had to resort to the extreme measure of a threat of legal proceedings, and that he certainly would carry the threat into execution if this kind of criticism were continued—(*Brit Med. Journal*, Oct. 28, 1882.)

Vaginal Lithotomy.—At the regular meeting of the New York Obstetrical Society, on the 16th of May last, Dr. Watts showed a vesical calculus which he had removed from a woman aged 55, who entered the Roosevelt Hospital, complaining of falling of the womb, the perineum was badly torn and there was prolapsus of the rectal and bladder walls. On examining per vaginam, a hard mass could be felt through the vesical walls, she had symptoms of severe cystitis, having to pass water every few minutes, and being unable to walk. A long incision was made through the vesico-vaginal septum, and the stone was removed. The incision was closed, a catheter was introduced into the bladder, and all went well, pain being relieved, until the ninth day, when leakage took place through a small point in the line of incision, though sloughing was more extensive on the vaginal edges of the wound. Cleanliness was observed; after ten days the leakage ceased, and the patient went on to complete recovery, all her former symptoms having disappeared. Drs. Pallen and Lee took part in the discussion which followed; both gentlemen commended the practice so ably advocated by

Emmet, of leaving the wound open to facilitate the cure of the cystitis which is always present to some extent with calculus. The removal of vesical calculi by this method in preference to that through the urethra is I am happy to say becoming general. A vesico-vaginal fistula thus produced by operation can always be cured, but dilatation of the urethra for removal of calculus has often been followed by permanent incurable incontinence. (*Supplement to the American Journal of Obstetrics*, Nov. 1882).

(*To be continued.*)

Reviews and Notices of Books.

A System of Human Anatomy, including its Medical and Surgical Relations.—By Harrison Allen, M.D., Professor of Physiology in the University of Pennsylvania. Section I.—Histology. Section II—Bones and Joints. Philadelphia: Henry C. Lea's Son & Co.

The first two parts of this long looked-for work have been issued, and we may judge in some measure from them what the prospects are for a standard American work on Anatomy. Active as our neighbours are in issuing medical publications, no native treatise in anatomy of any pretension exists, and this attempt of Prof. Allen to supply such a deficiency, to remove such a reproach, is in the highest degree commendable He has had, moreover, the necessary training and experience for that task, and in both human and comparative anatomy enjoys the reputation of an able teacher and an original worker. The first section, on Histology, is by Dr. Shakespeare, and comprises nearly 100 double-column quarto pages—12 plates and 63 woodcuts in the text. This part shows careful preparation, and gives a full exposition of the minute anatomy of the tissues. A larger number of original figures would have been an improvement; we are sure Dr. Shakespeare could have furnished them. Section II., Bones and Joints, brings us into the author's company, and we must confess to having spent several pleasant and profitable hours with him. The bones, indeed, are dry, but he clothes them and endows them with vitality and interest by regarding them as much

from the standpoint of the practitioner as the anatomist. This we consider the chief feature of the work, and the one which gives it special value, as in no other work that we know of is the same amount of valuable and suggestive information given. Take, for instance, the inferior maxilla : a page suffices for the technical description, while nearly four pages are devoted to practical considerations, in which the various surgical and pathological conditions of the bone are enumerated in relation to the anatomical structure. In each instance, in the remarks which follow the systematic account, the attention is directed to points of medical or surgical interest. A very useful section is that on the identification of bones for medico-legal purposes, which contains information not often met with either in anatomical or medico-legal works. The plates are, as a rule, well executed and clear, and have the name of each part engraved on the figures. Some of them are a trifle coarse, but, on the whole, they compare favourably with those in other large anatomical works. We have said enough to show our appreciation of the undertaking, one involving immense labour on the part of the author, but, when completed, we feel sure that the position it will take in the profession will more than recompense him, and we shall now have to add to the standard works of Henle, Hyrtl, Sappey, Quain and Grey, that of Allen.

A Guide to Therapeutics and Materia Medica.—By Robert Farquharson, M.D., Edin., L.R.C.P., Lond., late Lecturer on Materia Medica at St. Mary's Hospital Medical School. Third American edition, revised by the author. Enlarged and adapted to the U.S. Pharmacopœia by Frank Woodbury, M.D., Physician to the General Hospital, Philadelphia. Philadelphia : Henry C. Lea's Son & Co. Montreal : Dawson Bros.

It is by no means surprising that Dr. Farquharson's Therapeutics has already reached a third edition in the United States. It is constructed upon a plan which brings before the reader all the essential points with reference to the properties of drugs—impresses these upon him in such a way as to enable him to take

a clear view of the actions of medicines and the disordered conditions in which they must prove useful. His double-columned pages—one side containing the recognized physiological action of the medicine, and the other the diseases in which observers, (who are nearly always mentioned), have obtained from it good results—is a very good arrangement. The early chapter containing rules for prescribing is excellent, and will repay perusal to every one beginning to take charge of patients. We have much pleasure in once more drawing attention to this valuable and well-digested book, and predict for it a continued successful career.

Practical Laboratory Course in Medical Chemistry. By JOHN C. DRAPER, M.D., LL.D., Professor of Chemistry in the Medical Department, University of New York, and of Physiology and Natural History in the College of the City of New York. New York: Wm. Wood & Co.

This is an excellent handy manual for the use of students in the chemical laboratory. It is systematically arranged and presented in a very convenient form, alternate pages remaining blank for notes required at the various sections. It is divided into four sections. I.—Poisons, organic and inorganic. II.—Water. III.—Animal Fluids. IV.—Sediments and Calculi. The directions for examination and analysis are all given in short paragraphs, numbered for easy reference. We have no doubt it will prove a useful guide, and will be appreciated both by teachers and students.

The Multum in Parvo Reference and Dose Book.—By C. HENRI LEONARD, M.A., M.D., Professor of the Medical and Surgical Diseases of Women and Clinical Gynæcology, Michigan College of Medicine. Detroit: The Illustrated Medical Journal Co.

A very cheap little book—30 cents—containing a variety of information on different subjects. New remedies and preparations, doses of medicines, incompatibles, poisons and antidotes, tests, obstetric memoranda, visceral measurements, &c. Dr. Leonard

has had much experience in compiling condensations of this kind, and this one no doubt will be found a useful companion.

What to do in Cases of Poisoning.—By Wm. Murrell, M.D., M.R.C.P., Lecturer on Materia Medica and Therapeutics at the Westminster Hospital, Assistant Physician to the Royal Hospital for Diseases of the Chest. Second edition. Detroit: Geo. S. Davis.

This is a little vest-pocket book which will be found a most useful and reliable remembrancer. It is written by one of the best-known practical experimenters with drugs, and contains short directions for the treatment of poisoning by almost all the known hurtful medicinal agents, or those used in the arts and trades. It is just what every one should have by him for use in emergencies.

The Physician's Visiting List for 1883.—Thirty-second year of its publication. Philadelphia: P. Blakiston, Son & Co.

The arrival of the annual Visiting List is one of the indications that another year is nearly done, and that the physician must provide himself with a new almanac for the coming one. Blakiston's list is perhaps more widely known and used than any other. It is as neatly gotten up, as compact, as well printed, and furnished with as good paper as it always is. We only need to notice its reception so as to call our readers' attention to it, so that they may furnish themselves with what has come to be an essential part of the doctor's outfit.

Books and Pamphlets Received.

Medical Electricity, A Practical Treatise on the application of Electricity to Medicine and Surgery. By Roberts Bartholow, A.M., M.D., LL.D. Second edition enlarged and improved, with one hundred and one illustrations. Philadelphia: Henry C. Lea's Son & Co.

The Diseases of the Liver, with and without Jaundice; with the special application of Physiological Chemistry to their diagnosis and treatment. By George Harley, M.D., F.R.S. Philadelphia: P. Blakiston Son & Co.; Montreal, Dawson Bros.

Quiz-Compends, No. 1., Questions on Human Anatomy. By Samuel O. Potter, M.A., M.D. Philadelphia: P. Blakiston Son & Co.; Montreal, Dawson Bros.

On Slight Ailments, their Nature and Treatment. By Lionel S. Beale, M.D., F.R.S. Second edition. Philadelphia: P. Blakiston Son & Co. Montreal, Dawson Bros.

The Illustrated Quarterly of Medicine and Surgery. Edited by Geo. Henry Fox and Frederic R. Sturgis. Vol. I, No. 4. New York: E. B. Treat.

The Sympathetic Diseases of the Eye. By Ludwig Mauthner, M.D., translated from the German by Warren Webster, M.D., and James A. Spalding, M.D. New York: Wm. Wood & Co.

Lectures on Electricity in its relations to Medicine and Surgery. By A. D. Rockwell, A.M., M.D. New York: Wm. Wood & Co.

An Index of Surgery: being a Concise Classification of the main facts and theories of Surgery for the use of senior Students and others. By C. B. Keetley, F.R.C.S. New York: Wm. Wood & Co.

The Incidental effects of Drugs, a Pharmacological and Clinical Handbook. By Dr. L. Lewin, translated by W. T. Alexander, M.D. New York: Wm. Wood & Co.

Diseases of the Rectum and Anus. By Charles B. Kelsey, M.D. New York: Wm. Wood & Co.

Materia Medica and Therapeutics, (Inorganic Substances). By Charles D. F. Phillips, M.D. New York: Wm. Wood & Co. Vols. I and II.

The International Encyclopædia of Surgery. A systematic treatise on the theory and practice of Surgery by authors of various nations. Edited by John Ashurst, Jr., M.D. In six months, Vols I and II. New York: Wm. Wood & Co.

The Students Manual of Venereal Disease, being a Concise Description of these affections and of their Treatment. By Berkeley Hill and Arthur Cooper. Second Edition. New York: Wm. Wood & Co.

Suppression of Urine, Clinical Descriptions and Analysis of Symptoms. By E. P. Fowler, M.D. New York; Wm. Wood & Co.

A Clinical Handbook of the Diseases of Women. By W. Symington Brown, M.D. New York: Wm. Wood & Co.

A Treatise on Diseases of the Eye. By Henry D. Noyes, A.M., M.D. New York: Wm. Wood & Co.

A Handbook of Uterine Therapeutics, and of Diseases of Women. By Edward John Tilt, M.D. New York: Wm. Wood & Co.

Lectures on Diseases of Children. By Dr. Edward Henoch. New York: Wm. Wood & Co.

On Asthma, its Pathology and Treatment. By Henry Hyde Salter, M.D., F.R.S. New York: Wm. Wood & Co.

Artificial Anæsthesia and Anæsthetics. By Henry M. Lyman, A.M., M.D. New York: Wm. Wood & Co.

A Treatise on Food and Dietetics, Physiologically and Therapeutically considered. By F. W. Pavy, M.D., F.R.S. New York: Wm. Wood & Co.

Practical Medical Anatomy: A guide to the Physician in the study of the relations of the viscera to each other in health and disease. By Ambrose L. Ranney, A.M., M.D. New York: Wm. Wood & Co.

Mental Pathology and Therapeutics. By W. Griesinger, M.D. Translated from the German by C. Lockhart Robertson, M.D., Cantab, and James Rutherford, M.D., Edin. New York: Wm. Wood & Co.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, Oct. 20th, 1882.

R. A. Kennedy, M.D., President, in the Chair.

Pathological Specimens.—Dr. Osler exhibited the following specimens :—

1st. A specimen from a case of fatty diarrhœa, sent by Dr. Wolverton, of Hamilton. A woman æt, 30 had suffered for some weeks with gastro-intestinal disturbance, and for the past two weeks the dejections contained a remarkable amount of fat. Dr. Wolverton has promised a full report of the case.

2nd. A portion of the paunch of a cow presenting numerous examples of "Amphistoma Conicum," a fluke not uncommon in this region in "Ruminants." It would appear to be particularly abundant in the animals in Pictou County, N.S.

3rd. Specimens of obliterated superior vena cava from a patient of Dr. Wilkins, who had been in the hospital some twelve weeks with symptoms of venous obstruction in the thorax, lividity and swelling of face and upper extremities, with attacks of intense dyspnœa. Constantly accumulating effusions occurred into the left pleural cavity, necessitating frequent tappings. The superior cava was obliterated in its entire length and converted into a firm fibrous cord, about the thickness of the thumb. The internal jugulars and innominata contained fine thrombi undergoing fibroid transformation. Between the ascending aorta and the right lung there was a good deal of cicatricial tissue covering over and surrounding the obliterated vein. No heart disease or other lesion found.

4th. Specimen of a case of pneumonia terminating in abscess of the lung. The patient was under care of Dr. Molson in the hospital, a very intemperate woman aged 35, brought to hospital on the 4th day from onset of a severe pneumonia of the left lung, following a heavy drinking bout. On the 10th day she spat up large quantities of stinking purulent matter, and at the same time the temperature, which had remained about 104°, fell to 99°. She died on the following day.

Dr. Osler then exhibited some eighteen ounces of bile, obtained by aspirating the gall bladder of a patient, having the following history:

C. M. S., æt. 58. farmer, of fairly good health, with phthisical history on mother's side. In the month of April last first felt pain in back and shoulders and across the kidneys, did his spring work and did not consult any doctor. Early in June he noticed his water was dark, and his face became jaundiced and deeper than at present. Never had any paroxysmal pain, but pain was of a dull heavy character; no vomiting, lost much flesh in last two months, clay-colored stools, great itchiness, sleepless, appetite good. Present condition: Well-preserved man, not very grey, skin jaundiced, walks bent because of pain, conjunctivæ stained, tongue clean, breath not bad, abdomen flat, a little prominent in right hypochondriac region; liver dullness greatly increased, and a rounded mass is felt on right side of abdomen, corresponding to upper half of area of increased dullness, movable, elastic and evidently connected with the liver; surface of liver below costal border not roughened, a little tender below xyphoid cartilage. The distended gall bladder was aspirated, and about 18 ozs. bile removed, but without much benefit; nature of obstruction not quite clear; no history of gall stone.

Dr. Bell exhibited a bladder in a state of phlegmonous inflammation from a patient who died in the hospital from the effects of fracture of the spine.

Dr. Shepherd exhibited two femora which belonged to an old woman æt. between 80 and 90 years, the subject of general "Fragilitas Ossium," or senile atrophy of bones. The left femur had the characteristic deformity of osteo-arthritis, the neck being shortened and the head enlarged; the acetabulum of that side was much enlarged also. In this femur there was an old united fracture just above the condyles. In the right femur there was an ununited intracapsular fracture. Dr. Shepherd remarked that all the bones presented the atrophic condition, the skull cap in particular, being only of parchment thickness. The astragalus could be easily broken down between

the finger and thumb ; very slight accidents in these cases are liable to produce fracture.

Cancer of Œsophagus.—The next specimen was exhibited by Dr. Geo. Ross, who also made a few remarks on the history of the case. The patient from whom the specimen was taken, J. M., æt. 54, was admitted into the General Hospital Oct. 10th, 1882, complaining of cough, pain in epigastric region and weakness. In May had pain in midsternum and to the left side. In June had frequent vomiting ; after a time solids seemed to be stopped on the way down, to roll about in his stomach, and then would be at once brought up. Has lived on soft toast, tea, and milk for a long time. Has been intemperate. Began to cough three weeks ago, and soon noticed a very foul smell coming up his throat with the cough.

Status Præsens—Anæmic and emaciated, pulse weak ; sharp bubbling sounds heard at base of right lung to spine of scapula and into the axilla. Expectoration serous with purulent masses, faint fetid odor. Liver felt greatly enlarged, smooth and very little tender. A large-sized bougie was passed readily into the stomach, no obstruction ; was made to swallow dry bread, which he did well. In spite of the negative signs given by the passage of the bougie the case was considered to be one of cancer of œsophagus with secondary affection of lung, and fatty or cancerous liver.

Post Mortem.—The œsophagus presented an enormous cancerous ulcer situated in its lower half, extending for about four inches and involving nearly the whole circumference of the tube with the exception of a narrow tube-like portion on the posterior wall. The edges were swollen and infiltrated, and the base presented a deep excavation which at the right margin had perforated the lung, and formed near the root a series of sloughy abscesses in an area about the size of an orange ; there were extensive secondary masses in the liver, particularly in the left lobe.

Remarks on Specimens Exhibited.—Dr. Mills, in cases of cancer of œsophagus, thought the passage of the bougie might be explained by a peculiar turn of the instrument ; he thought

it would have been a good case for auscultation of the œsophagus. Dr. Ross, on the other hand, thought auscultation would have also failed inasmuch as there was no obstruction; he thought œsophagoscopy would have been more serviceable. Dr. Mills then explained the mechanism of Morrell Mackenzie's apparatus for œsophagoscopy. He did not agree with Dr. Ross in regard to auscultation, the œsophagus being a closed tube. Although no obstructions were present its walls were so diseased that they could not act muscularly, and thus, in swallowing, the sounds would be delayed sufficiently to be appreciated by means of the stethoscope. Dr. Osler also agreed with the last speaker; he had had some experience in œsophageal ascultation in the Vienna Clinique, and the difference in the sounds was very marked. Dr. Henry Howard, speaking in regard to the bones exhibited by Dr. Shepherd, remarked that such a condition was frequently found in aged persons of unsound mind, and accidents were frequently occurring in lunatic asylums from very slight causes, owing to this fact.

Dr. Roddick reported a case of laceration of the left kidney, followed by death on the fourth day. The case occurred in the practice of Dr. Simpson, with whom he had seen the patient in consultation. The patient, a woman of sixty years, but remarkably healthy and vigorous, fell accidentally from the top to the bottom of a long stairway, and was picked up in an insensible condition. There was no wound to be found, but she complained from the first of great pain in the right loin. Vomiting soon began, and, in spite of all treatment, continued to the end. The bowels became tympanitic, and refused to act. The most marked symptom, however, was the passage of pure blood from the bladder. This formed a large clot in the vessel, and urine was for some hours almost absent. The urine after the first twenty-four hours became more and more smoky, until, on the fourth day, it was almost bloodless. Rupture of the kidney was diagnosed, and, on account of the obstinate condition of the bowels, ileus was suspected, although no tumor could be felt. The long O'Beirne's tube was passed, and a large injection thrown into the bowel, but with no effect. At the autopsy a

large clot of blood was found surrounding the right kidney, and a rent through the border of the organ, communicating with the pelvis, whence the blood evidently came. The kidneys were slightly granular. The bowels were found unobstructed, although it was thought that the blood clot might have pressed unduly on the ascending colon, and interferred with its functions.

Clinical Notes on Hæmatemesis in Chronic Splenic Tumors.—This paper was read by Dr. Osler. (*See page* 267.)

Discussion on Paper.—Dr. Buller asked for information as to the supposed possible cause of hæmorrhage in these cases, if mechanical or due to condition of blood. Dr. Osler replied that in some cases it would seem to be due perhaps to a feeble condition of the vessels as in leucocythemia and pernicious anæmia. In the cases under notice it might be explained by mechanical causes, considering that three-fourths of the blood from the stomach is discharged into the splenic vein, and in engorgement of the latter a sweating or diapedesis might be conceived as occurring from the vessels of the stomach.

Dr. Ross spoke of the obscurity connected with such accidents occuring under such peculiar circumstances, and the exact condition giving rise to them. In the early stages of cirrhosis we also have profuse hæmorrhages, and possibly the cases are of a parallel nature ; probably other conditions have something to do with it. The great depression in mind spoken of in connection with one of the cases might have influenced the nerve supply of the blood vessels, allowing more or less dilatation of the splenic vein and damming back the blood into the gastric veins.

In reply to a question by the President, Dr. Osler said that he had used injections of ergotine, but could not say with much benefit.

Dr. Stephen remarked that in a recent number of the *Lancet* injections into the substance of the spleen had been condemned as being dangerous and unadvisable.

Dr. F. W. Campbell thought that something would be required to act more quickly than ergotine, and suggested that

the application of the ice-bag to the pit of the stomach would be especially good.

Stated Meeting, November 3rd, 1882.

R. A. KENNEDY, M.D., PRESIDENT IN THE CHAIR.

Dr. Major read a paper on papillomatous growths of the larynx, reporting two cases of simple papilloma, one of warty growth, in a case of rapid tuberculosis, and one of warty growths of the velum palati.

Discussion on Paper.—Dr. Osler, in reply to Dr. Major in regard to the pathology of papilloma of the vocal cords, said he did not think it differed from ordinary papilloma of other regions; those of the larynx seemed to be abnormal growths of the epithelial layers. He asked Dr. Major if it were possible to distinguish this growth from an epithelioma, and whether it ever passed into an epithelioma.

Dr. Roddick in speaking of the operation referred to by Dr. Major, at which he assisted, expressed his pleasure at the skillful manner in which the tumor was removed, although not unattended with difficulty, the tumor being he thought larger than it appeared by the laryngoscope, and at one time the patient being in a very alarming condition. He asked Dr. Major why he did not remove growths by opening the thyroid cartilages, and if it would not be preferable to have permanent aphonia than necessitating the continual carrying of a tube.

Dr. Mills said growths of this kind and their removal were very debatable subjects. Morrell McKenzie prefers their removal, and by evulsion, while Lennox Brown says that benign growths often become malignant even when well removed, whereas McKenzie does not think so. He thought from his experience that they are of more frequent occurrence than Dr. Major had shown. Malignant disease cannot be diagnosed if you rely on ordinary signs, as the glands, cachexia and pain. He thought it a mistake after the removal of such growths to allow the patient to return home, as subsequent cauterizations are always advisable. Evulsion he considered as not being

always practicable. He also spoke of the advisability of educating the throat not only by the physician but also by the patient to render skilful examination practicable In all cases of aphonia careful examination of the throat should be made early. He would object to thyrotomy unless to save life.

Dr. Major in reply said it was exceedingly difficult to diagnose between the epithelioma and papilloma, as a rule time and history alone will decide. In this case thyrotomy was thought of, but the hope that the growths would ultimately disappear led him to put it off. And as a rule the tracheotomy tube is well borne.

A Proposed Vaccine Institute.—Dr. Bessey read a paper on this subject. He commenced by referring to the history of animal vaccination in Canada, the first attempt towards which was in the year 1875 in this city, but which for some reason or other was in a short time abandoned, and about the same time in a town in Ontario an attempt was made to furnish animal virus to the profession, but it also was soon discontinued. In 1877 a spontaneous epidemic of cow-pox having occurred at Longue Pointe, Dr. Bessey was afforded opportunity of procuring abundance of lymph, which he continued to furnish to the Montreal Board of Health for two years. In 1880 an allowance of twenty dollars per month was voted by the Board as a permanent subsidy to defray the expenses incurred in keeping the animals required, Dr. Bessey agreeing to furnish the Board (for the use of the public vaccinators) from time to time with such an amount of lymph as experience showed was necessary, each vaccinator being charged to collect the lymph from his first vaccinations to continue the service until the distribution of the next supply. An estimate given of the numbers vaccinated during the years 1878, '79, '80 and '81, compared with the average birth rate and allowing 25 per cent. to be deducted for death rate, shewed that there must remain a large number still unprotected. In the year 1872 there were 872 deaths from small-pox, and in the four following years 728, 647, 590, and 704 respectively. Prior to 1877, when animal vaccination was introduced, public opinion in certain quarters had been

very strong against general vaccination, till the people becoming convinced of its safety began to submit very generally to the operation, after which the prevalence of small-pox began to decline, and has finally disappeared altogether. The deaths in 1877 amounted to 506 and in 1878, 728, in 1879, 472; in 1880, 140; in 1881 only 5 deaths occurred, and this year there have been no deaths so far. It had been found by experience that lymph one or two removes from the animal gave the most perfect results; and while animal vaccine guarantees against the transmission of syphilis (which has been shown by well-authenticated cases to occur with the use of humanized lymph, however rarely), and while it is believed to afford perfect immunity from attacks of small-pox, yet it is the experience of many that frequently there is difficulty in making preserved vaccine "take" on the human subject, the average number of successes being about 80 per cent., whereas those of the 1st human remove average 98 per cent. This difficulty the reader of the paper thought could be removed by: 1st. An ample and constant daily supply; 2nd. Its careful preservation or immediate use; and, 3rd. The establishment of a national vaccine institute. Dr. Bessey stated that in the United States lately serious consequences had followed the use of so-called vaccine lymph furnished from some 14 vaccine farms, which fact, on investigation, was found to be due to the want of skill on the part of those employed in its collection. For some time past Dr. Bessey has been striving for the establishment of such an institution as the one proposed, and many petitions have been sent to the Government, but without receiving much more than a bare recognition, until, lately, the Joly Government offered ten acres of the Government farms at the Tanneries in perpetuity, but they had no money to put buildings thereon. More recently the Chapleau Government signified its willingness to vote a small annual subsidy, and also continue Mr. Joly's offer, provided the Dominion Government would build, or aid in putting up the necessary buildings. This was the subject of a letter to the Hon. J. H. Pope, the Minister of Agriculture, who replied that, while recognising the advan-

tage of such an institution, there was no vote from which the sum of money could be furnished. In the meantime a new Premier and a new Government have come into power, to whom application would have to be made to ratify the offers of the two former Premiers; and while awaiting the action of the Government Dr. Bessy thought the Society, by concerted action, might do much, whereby a suitable building might be erected, and thus have the grant of land secured at any rate. Dr. Bessey submitted to the Society a plan of such an establishment as he thought would be desirable, which would call for an outlay of about five thousand dollars, to build, equip, and put in running condition.

Discussion on Paper.—Dr. Hingston stated that to the efforts of Dr. Bessey was very much due the removing of the strong opposition on the part of the French, by using animal virus in vaccinations; he, however, took exception to the view of Dr. Bessey in regard to the transmission of syphilis by vaccine lymph, which was believed to be impossible by some of the ablest men in Europe; but, when such infection did occur, it was through the blood of the crust and not from the lymph.

Dr. Osler asked Dr. Bessey for definite figures as to the proportion of figures of children vaccinated direct from the heifer and those from humanized vaccine. In regard to the absolute immunity of pure lymph he took it that Dr. Hingston meant that the syphilis is conveyed in the formed matter of the blood, and, if conveyed in the red blood corpuscles, why can it not be also carried in the white cells? Now it is a fact that you cannot get lymph without colourless corpuscles; if you take it ever so pure and clear it will contain a few colourless cells, and as it gets older these multiply by taking nourishment from the lymph.

Dr. F. W. Campbell said that the Local Government should be conferred with to have an Order-in-council passed donating the land, and then the Dominion Government should be asked for a grant towards putting up the buildings. He thought it very important that a large stock of animal virus should be always obtainable, and he thought the Society should act with Dr. Bessey in this matter.

In reply, Dr. Bessey said in the absence of positive records, he should judge that 50 per cent. of the cases were vaccinated from the heifer lymph, and the remainder with early removes from healthy children. In reply to Dr. Hingston, he held that the serosity of vaccine was quite capable of being the medium for conveying the syphilitic germs, as readily as a pus granule or blood corpuscle; it was as much a secretion of the body as was the saliva, the perspiration, or the seminal fluid, either of which, as has been frequently demonstrated, are capable of transmitting the syphilitic poison.

It was then moved by Dr. Hingston, and seconded by Dr. Campbell, and resolved: "That this Society desires to express its deep appreciation of the necessity that exists for a sufficient supply of reliable bovine vaccine lymph, and expresses its confidence in the purity of the supply afforded by Dr. Bessey during the past few years, and will hail with satisfaction any assistance the Local and General Governments may be pleased to afford in order to secure an efficient supply for the Dominion of Canada."

The matter was then referred to the Council to take action.

Dr. Hingston laid before the Society several "proofs" of a pamphlet now being printed for him, as a note-book on ovarian and other abdominal tumors. He said that those of Spencer Wells and Hodges were more than complete in the matter of history, but incomplete in what related to diagnosis. While many diseases with which ovarian tumors might be confounded were to be found in the pamphlets of those writers, much had been omitted, and to supply these omissions was the purpose of the pamphlet. Dr. Hingston stated he had followed the arrangement by Hodges, and restored much of what had been omitted from Wells, and had supplemented, chiefly under the head of diagnosis, what was not to be found in the note-books of either.

CANADA

Medical and Surgical Journal.

MONTREAL, DEC., 1882.

VITAL STATISTICS.

It has long been apparent that the Dominion Government are really anxious to provide for some systematic supervision of the public health, and will not remain content simply with words and promises. The medical profession have been for many years taking a deep interest in the progress of movements tending in this direction, and have repeatedly, through the Canada Medical Association and their own journals, called upon our legislators for a comprehensive scheme by which to regulate sanitary matters throughout the country. One of the very first steps necessary is to establish some uniform method for the collection of vital statistics. As our readers are aware, a small sum was appropriated at the last session of Parliament for this purpose. This practical move has set on foot a good deal of discussion in all our towns and cities. Hon. Mr. Pope, who has throughout exhibited great earnestness in this matter, arranged for a representative delegation from the various Health Boards and from the medical profession to meet himself and some of his colleagues at Ottawa and have a general discussion and interchange of views. This interesting and important event took place in that city on the 7th inst. The following delegates were present:—

Montreal—Col. A. A. Stevenson, Ald. J. H. Mooney, Mr. F. N. Boxer, J. A. U. Beaunry, C.E., Ald. Fairbairn, Drs. Hingston, Howard, Larocque, Campbell and Mount. Quebec—Mayor F. Langelier, Drs. Roy, R. F. Rinfret, N. E. Dionne. Toronto—Drs. Oldright, Canniff, G. Wright and Playter. Ottawa—Dr. P. St. Jean, Mayor; Drs. J. A. Grant, John Sweetland, S. Wright, H. Wright, H. Hill, H. B. Small, F. X. Valade, A. Robillard

(Health Officer), R. Mark and A. J. Horsey. Halifax—Drs. Wickwire, Moren, Almon, Farrell, W. H. Maloy, M.P.P., and Mayor Fraser. Charlottetown—Dr. Conroy. St. John, N.B.—Drs. Botsford, Harding. Daniel and Bayard. Fergus—Dr. G. Orton, M.P. Londonderry—Dr. Macdonald.

The delegates were received by the Hon. Mr. Pope, Sir Chas. Tupper and the Hon. A. P. Caron. Hon. Mr. Pope explained the present state of things and the desirability of effecting a radical change. A general discussion ensued, when the following resolutions were passed, which sufficiently show the gist of the various speakers' remarks :—

Resolved,—That, in the opinion of the meeting, in order the better to prevent disease and preserve human life, it is advisable that the Dominion Government should organize and sustain a uniform system of vital statistics for the Dominion.

Resolved,—That, as immediate action is necessary, the Federal Government be invited to initiate at once a system of vital statistics where organized Local Boards of Health are established, so that the statistical information may be utilized by these bodies.

Resolved,—That, as Provincial legislative action is necessary, it is suggested to the Federal Government that it communicate with and secure the co-operation of the Provincial Government to pass such legislation as will harmonize with and obtain the object of the preceding resolutions.

Resolved,—That it is desirable that a central bureau of statistics be established, and if found to be within the province of the Federal Government, a comprehensive system of health returns.

Resolved,—That inasmuch as it appears by the British North America Act that matters of public health are delegated to the Local Government, this delegation has not included it with the subject of vital statistics; nevertheless, they are of opinion that it would have been better had it been under the direction of the Federal Government, and beg to suggest that an effort be made to obtain an amendment to the constitution in that direction.

Sir Charles Tupper urged that a united effort should be made to obtain power for the Federal Government to take charge of a General Sanitary Bureau. As these matters are now placed under the Local Governments and the municipal authorities by the British North American Act, it will be necessary for them separately to petition for permission to resign their functions to the central authority. If, then, the latter represent to the Imperial Government, their willingness to assume control of the Sanitary Departments, it is most probable that an amendment to that effect to the Confederation Act could be obtained.

The suggestion of Sir Charles Tupper is well deserving of

attention, and we hope that before long it may have secured the desired result. On the whole, the deputation was a most successful one, and we congratulate its members upon having, in some cases at considerable sacrifice of time, thus aided in furthering a work which may yet prove of inestimable benefit to the whole country.

CHRYSOPHANIC ACID IN THE TREATMENT OF PSORIASIS.

Any one who has had experience in the treatment of this disease by the old-fashioned method with tar ointment, and who employs chrysophanic acid for the first time, cannot fail to be struck with the almost marvellous effect of this drug. Yet there are many in the profession who do not know its value, and there are a few who doubt its efficacy. At a recent meeting of the New York Dermatological Society, this was made the subject of a very interesting discussion, and certain conclusions were then formulated and pretty generally agreed upon, which we consider of sufficient value to present to our readers :—

1. That chrysophanic acid is perhaps the most efficient agent known to the profession for the external treatment of certain cases of psoriasis, especially chronic cases which have resisted other methods of treatment.

2. That its range of application is limited ; in children, in patients with sensitive, irritable skins, and acute cases, generally, it is contra-indicated.

3. That in psoriasis affecting the face and hairy scalp, the intensely irritating action producing puffiness of the face and eyelids, and its discoloring effect upon the hair render its employment impossible.

4. That it is prompt in its action, a week or ten days' active treatment being usually required to develop its full therapeutic efficacy.

5. That its curative effect is only temporary ; it does not afford a safeguard against relapses.

6. That it probably acts only locally and by virtue of its irritating properties, setting up a substitute inflammation, which modifies or corrects the tendency to overgrowth of epidermic cells.

7. That its employment is attended with certain objectionable results, some of which always follow its use, while others seem to depend upon idiosyncrasy, physiological and morbid predispositions, etc.

8. That a brownish, prune-juice discoloration of the skin which persists long after the application is discontinued, a reddish staining of the hair and nails, and an indelible dyeing of the clothing are inseparable from its use.

9. That the erythematous and furuncular inflammations which occasionally follow its use may be classed as incidental effects, as they do not always depend upon an excessive strength of the preparation employed, but are frequently manifest after a mild application ; intense dermatitis,

resulting in exfoliation of the epidermis in large flakes, has been observed after an application of 10 grs. to the ounce.

10. That the strength of the ointment recommended by Balmanno Squire (℥ii to ℥i) is excessive; a milder strength (20 grs.-℥i to ℥i) being usually sufficient to develop the full therapeutical virtues of the drug.

11. That in other diseases for which it has been recommended, as acne, favus, pityriasis versicolor, eczema marginatum, etc., chrysophanic acid possesses no advantages over certain other drugs which are commonly used.

Pyrogallic acid was thought to be the best substitute for the other in cases where the skin was unusually sensitive, or where the disease attacked the scalp and face. With regard to the strength of the ointment of chrysophanic acid, in our own experience we have never found it necessary in any case to employ a stronger application than one containing 10 grains to the ounce. In one case, which we are in the habit of citing, a strong man was made alarmingly ill by the application of an ointment of the above strength. The case was one of general diffuse psoriasis, and on the second day of the treatment he was seized with a rigor, his temperature rising to 105°, and the body was found soon after to be covered with a rash identical in many of its characters with that of scarlet fever. This peculiar action of the drug was not understood at the time, so that some uneasiness was felt for the moment. The feverish symptoms of course rapidly subsided, and a complete cure of the psoriasis followed. Ever since, we have preferred, especially in private practice, to feel our way, by commencing the treatment with an ointment not stronger than six grains to the ounce. One of the greatest objections raised against chrysophanic acid is its unfortunate property of staining the clothing. This can be obviated in great measure by employing a species of varnish recommended by Dr. Fox of New York. This is made by suspending about 10 per cent. of the acid in flexible collodion. By rubbing up the powder first with a little alcohol and ether, and then adding the collodion and shaking, a more uniform mixture is made. Dr. Fox thinks that the varnish is not quite so efficacious as the ointment, but, after drying for ten minutes, will not stain the clothing.

CAUSES OF CONSUMPTION.

Last year Dr. Playter of Toronto addressed a circular to a large number of medical men in Canada and the United States,

containing a series of questions relative to the personal condition and hygienic surroundings of phthisical patients. He has now published a small pamphlet which embodies and tabulates the answers received from his correspondents with reference to 250 cases of well-marked tubercular pulmonary consumption. The results arrived at, as might have been anticipated, confirm many of the well-known facts concerning the etiology of pulmonary tuberculosis. A few points, not so generally recognized, are emphasized by Dr. Playter in his general conclusions. "One of the most marked features, and perhaps the most important one, brought out in the analysis of the cases, is the evidence that those who die of the disease under consideration have a small pulmonary capacity—a small, contracted chest. This is shown not only in the average of the cases, but in every case—in not one did the circumference of the chest even approximate that of a well-developed individual of the same height and weight." Another point, specially interesting now with reference to the germ-origin of tubercle, is that of the contagiousness of phthisis. A considerable proportion of the reported cases, 28 per cent., had been known to be much and directly exposed to the disease, nursing and sleeping with friends suffering from it. The writer seems to accept the existence of the bacilli as the cause of the disease, and thus expresses the reason why contagion is not more frequently witnessed. "The bacilli of consumption in the human organism must meet with favorable soil and favorable conditions in which to propagate before they can give rise to the fatal malady. These conditions are secondarily through inharmonious and defective constitutional organization and want of vigor, coupled with, very likely, accumulations in the body of detrite matters, and, primarily, from want of capacity for the perfect performance of the respiratory function—from too small lungs." The practical inference from this is "to increase, in early life, by judicious physical exercise, the size and capacity of the respiratory organs."

CEASED TO EXIST.

We regret to have to announce that, with the issue and completion of its eighth volume, our esteemed contemporary, the

Archives of Dermatology, ceases to exist. The reasons given for cessation of publication are pressure of other work on the part of its talented editor, Dr. Bulkley, and the fact that a monthly journal devoted to the same specialty has recently appeared in New York. We shall miss the *Archives* from our table, having long regarded it as one of the most ably-conducted of our exchanges. The department of clinical reports and illustrations, conducted by the editor himself, has always been replete with practical suggestions, and must have been a great boon to the busy practitioner, whose time for reading is often so limited. While Dr. Bulkley has laid down the editorial pen, we trust he may be induced, from time to time, to give the profession the benefit of his vast experience, in the shape of a contribution to the literature of diseases of the skin.

Kingston Medical School.—We regret to see that trouble has arisen at the Royal College of Physicians and Surgeons of Kingston between the male and female students. Dr. Fenwick, in his physiology lecture, made some remark which was loudly applauded by the male students, but at which the ladies took offence and left the room. A meeting was then held by the students, and a memorial sent to the Faculty asking that the ladies should be excluded, and stating that if the request was not complied with the class would leave for some other school. The Faculty refuses to be dictated to, and so far a settlement of the difficulty has not been reached. Only about seven of the students have paid their class fees, so that the majority are in an awkward position, and cannot get their half session certified until all dues are settled with the school. We understand that an application for admission to McGill College was refused unless the half session was certified by the authorities and the students left "in good standing." We trust that an amicable settlement will soon be reached, and that this temporary difficulty will not interfere with the continued prosperity of the Kingston school.

The Toronto Schools.—A discussion has been taking place on the advantages of a union of the Toronto and Trinity Schools, and the *Mail* has interviewed many of the leading Toronto medi-

cal men on the subject. It is not at all probable that a fusion will be effected. Some advocate a Hospital School. Where is the Faculty of Medicine of Toronto University?

McGill Medical Society.—We are glad to hear of the flourishing condition of this useful organization, now in its seventh year. The state of the student's society at a medical school is a good index to the education and intelligence of the class of men in attendance. We do not hesitate to say that among the very best features of the Edinburgh and London Schools are the societies where the students meet and discuss various subjects. Constant attendance at a society is a valuable adjunct in the *education of a student.* A number of new books have been added to the library, and we notice that the materia medica cabinet is being utilized by the primary men.

Balfour Memorial.—The friends of the late Prof. Balfour, to whose untimely death we referred in the August number, have decided to establish a fund for the promotion of biological research, to be known as the Balfour Fund. A large sum has been already subscribed. In the last number of the *Archiv fur Mikroscopische Anatomie,* Prof. Waldezer of Strasburg pays a splendid tribute to the work and worth of this young investigator.

Nurses.—We are glad to observe that a systematic arrangement for the registration of nurses has been provided for in Toronto. This matter has been several times spoken of for the city of Montreal, but nothing has yet been done. It is a most desirable thing, and, when well managed, proves of great service both to the profession and the public. We should be glad to see a move made in this direction.

Annual Dinner of the Undergraduates in Medicine, McGill University.—This reunion will take place at the Windsor Hotel, on the 18th inst. An energetic committee are making all the necessary arrangements, and a very pleasant meeting is anticipated. We hope to see a large number of old city graduates amongst the subscribers.

—At a meeting of the senate of Toronto University, on the 8th inst., it was decided to establish nine Fellowships, tenable

for three years, with salaries of $500 per annum. No more important step in the interest of higher education has ever been taken by a Canadian University. At the same meeting, the enactment was cancelled which requires candidates for the M.D. degree to write the thesis in the Convocation Hall.

—A notorious character named Jean Jacques, *alias* Johnny Leblond, has recently been discharged from the common jail at Three Rivers after having served a term of three months' imprisonment. He was prosecuted by the Provincial Board for the illegal practice of medicine and fined $25 ; being unable to pay, he went to prison. He hailed from the Parish of St. Pierre les Becquets, Co. Nicolet, and it speaks well for the district that Johnny's coffers were so scantily filled. We also learn that an action has been entered in the name of the Board against Dr. James D. Stewart, of Belleville, Ont., for having practised medicine in the Province of Quebec without having taken out the license.

—We have received the Annual Report of the Surgeon-General of the United States Army for 1882. The Report is based upon an average mean strength of 20,778 white, 2,265 colored troops, and 245 Indian scouts. It contains some interesting statistical matter concerning the mortality in the army, both from disease and from wounds and accidents. The medical library of the Department at Washington now numbers 57,000 volumes and 63,700 pamphlets. By means of the enormously expensive catalogue now in course of preparation, this great mass of literature is being made available to the whole profession of the country.

Obituary.

Dr. Dickson of Kingston.—The presiding officer of the Kingston School of Medicine has also been called away, and it becomes our mournful duty to extend our sympathy to that Faculty at the loss which it has sustained. Dr. Dickson was born in Ireland in 1819, and received part of his medical education in Belfast and Glasgow. In 1837 he came to Canada, and for several years was with Dr. Hutchinson of Peterborough. In

1842 he took the license of the Provincial Board, and also graduated at the University of New York. In the same year he settled in Kingston, and for forty years occupied an honorable and prominent position in the community. In 1854 the Medical Faculty of Queen's College was organized, and Dr. Dickson became the President and Professor of Surgery. In 1863 he took the membership diploma of the London Colleges, and in 1867 the Fellowship of Royal College of Surgeons of Edinburgh. In 1866, when the Medical Faculty of Queen's became a separate corporation under the title of the Royal College of Physicians and Surgeons, Dr. Dickson was chiefly instrumental in obtaining the charter and in reorganizing the school. He had the honor of being the first President of the Ontario Medical Council, 1866. For ten years he was surgeon to the Penitentiary, and from 1869 to 1878 Medical Superintendent of the Rockwood Asylum. Dr. Dickson had an extensive reputation as a surgeon, and his zeal and abilities materially assisted in establishing the reputation of the Kingston School of Medicine. For several years he has been prostrated with paralysis, and had relinquished all professional duties, though retaining full possession of his faculties.

Dr. Russell, Sen., Quebec.—The old capital has lost one of its leading medical men by the death of Dr. Russell on the 7th inst. The deceased was a native of Quebec, son of the late Capt. Russell, and member of a family with strong medical predilections. Two brothers, Frank and John P., also studied medicine; the latter is one of the leading practitioners of Toronto. The subject of this sketch began his career as a student of Dr. James Douglass of Quebec, and then proceeded to Edinburgh, where he graduated with honors in 1843, taking obstetrical and anatomical prizes. Returning to Canada, he settled in his native town, where for over 40 years he has enjoyed the confidence of the public in a high degree. In all matters relating to the welfare of his profession, Dr. Russell took a lively interest. He was for over 30 years a governor of the College of Physicians and Surgeons of Lower Canada, and held the presidential chair. He was one of the original members of the Dominion Medical Association, and entered actively into the work of the Society in

the early years of its existence. The Doctor had a keen, sharp intellect, was a good debater, and never seemed so happy as in the heat of controversy. He was not a frequent contributor to the journals. His son has been in practice in Quebec for eight or ten years, and is a worthy representative of the family.

Professor Draper.—By the death of this distinguished man American science loses a bright ornament and the profession a member identified with its best interests. He was a son of the late Dr. J. W. Draper, the celebrated chemist and writer, and from his father received a thorough training in chemistry and medicine. He taught physiology for some years at the University School, was one of the staff of Bellevue Hospital, and a practising physician in New York city. Astronomy was his favorite study, and in this he made his scientific reputation. He was the most successful of celestial photographers, and had photographed the nebula of Orion and the spectra of more than 100 stars. The discovery with which his name will be chiefly associated is the presence of oxygen in the sun. He was a man of large private means, which were liberally spent in the cause of science.

Dr. Thayer of Burlington.—The profession of Vermont and the medical faculty at Burlington have sustained a heavy loss by the death of this well known physician. Born in 1817, he studied with his father and graduated in 1838. From 1854 he practised at Burlington, where he occupied a prominent position as a teacher, while his reputation secured an extensive practice. His opinion was held in high esteem by many of his Canadian colleagues on the border. To his energy and zeal the profession of Vermont owe the re-establishment of the Medical School at Burlington, which was founded originally in 1823, closed in 1836, and reorganized by him in 1854. After many struggles and difficulties, he had the satisfaction of seeing it placed on a solid foundation and the class list swell from 20 or 30 to near 200. During the war he organized the medical service of the State, and was appointed Surgeon-General. He was in active practice to the end.

Professor Gulliver.—This well-known anatomist and physiologist died at Canterbury, England, on the 17th ult., in his 78th year. He was for some years Hunterian Professor at the College of Surgeons, and is best known in connection with investigations on the blood and lymph.

Personal.

H. E. Poole, M.D. (McGill, '80), has moved to Ormstown, P.Q.

H. E. Heyd, M.D. (McGill, '81), has gone to Buffalo, N.Y.

J. C. Shanks, M.D. (McGill, '81), is at Howick, Que.

Dr. T. Wesley Mills has returned from a short professional trip to Colorado.

W. C. Cousins, M.D. (McGill, '82), has passed the L.R.C.P. and L.R.C.S., Edin.

H. V. Ogden, B.A. (Trinity), M.D. (McGill, '82), has commenced practice in Milwaukee.

Fred. H. Mitchell, M.D. (McGill, '72), who is at present practising in Winnipeg, was in town for a few days.

Kenneth A. J. McKenzie, M.D. (McGill, '81), has left for Portland, Oregon, where he intends commencing practice.

We regret to learn that Dr. J. J. Woodward, of the U. S. Army Medical Museum, has not been benefited in health by his residence in Europe ; no hopes are entertained of his recovery.

We are pleased to see that our friend and class-mate, Surgeon-Major Keefer of the Bengal Army, who has been serving with the Indian contingent in Egypt, has received the Order of Osmanieh for service during the war.

We have received the announcement of the University of Kansas City. Alex. Jamieson, B.A., M.D. (McGill,'77), is President of the Department of Pharmacy and Professor of Chemistry. The University is to be congratulated in having so competent a man at the head of such an important department.

In the recent elections for the Legislative Council of Prince Edward Island, Dr. Fraser was returned by a large majority for the first district of King's County. The Island physicians are

ardent politicians ; they have contested seven seats in the last Local and Dominion elections. We are sorry to learn that Drs. Robertson and Jenkins have both been unseated owing to some informality.

Medical Items.

—Mr. Geo. Critchett, the well-known London oculist, died on the 18th ult., aged 65, from cystitis and enlarged prostate. He is succeeded in the same specialty by his son, Mr. Anderson Critchett.

—Dr. Oliver Wendell Holmes has resigned the Chair of Anatomy in the Medical School of Harvard University, which he has held since 1847. The *Boston Medical & Surgical Journal* for November 2nd devotes its editorial to a sketch of his work during these thirty-five years.

—Mr. Oscar Clayton, F.R.C.S., has received the honor of knighthood in consideration of his services to the Prince of Wales. Some of the English medical papers consider this the result of Court favouritism only, and hold that many eminent names should have been thus distinguished before the one alluded to.

—The *New York Medical Journal* is to be published weekly, beginning with the New Year, instead of monthly, as hitherto. It will then have large, double-columned pages, affording space for certain new features, whilst its present *resumés* and other departments will be continued.

—The following would appear to be the very first Canadian record of a license to practise medicine in this country :—

"Le 2 Avril 1658, il est accordé une commission de Barbier-Chirurgien qui est plùs tard solennellement enregistrée au Conseil Supérieur. C'est le premier diplôme accordé pour la pratique de la médécine en Canada."

DOUTRE & LAREAU.

Droit Canadien, p. 41.

—Mr. Dujardin-Beaumetz, having had a long experience in the recent epidemic of typhoid in Paris, finds his success from an expectant plan of treatment equal to any of the so-called special methods. Baths give pneumonia. Quinine would be toxic if absorbed in full doses ; but it is not absorbed. Salicylic

acid produces no good effects. Carbolic acid is very dangerous. Charcoal is a simple disinfectant. He gives an occasional purgative, nourishment and support—and that is all.

Illness of Sir Thomas Watson.—This eminent physician has, we regret to learn, been prostrated by an attack of hemiplegia. He is now in his 91st year, and, up to the time of the seizure, had been in the enjoyment of excellent health. As we go to press, the news reaches us of the death of this Nestor of English physicians.

Rough on Rats.—In a Toronto contemporary Dr. Zimmerman draws attention to the highly dangerous nature of the compound sold under this name. One fatal case of poisoning has already occurred. It has been found, on analysis, to consist of 99 per cent. of white arsenic. It is said to be "a convenient preparation by which anyone can obtain a powerful poison."

Doctors *versus* Parsons.—Professor Frotheringham, of the Medical Faculty Michigan University, has got into difficulty by making the sweeping assertion, during a lecture, that all parsons were liars. A Rev. Mr. Morgan, a student of the Faculty, instituted charges against the Professor, which were not sustained, and Dr. Frotheringham has been supported in certain counter charges which he made against his clerical student.

Floating Kidneys.—Mr. Lawson Tait does not believe in the existence of this condition. He says: "I put the floating kidney theory altogether on one side, because I have never seen such a thing, either in life or in a museum, nor have I met any one who has. In fact, I have no belief in its existence as a pathological incident." An opinion widely at variance with that of a host of competent pathologists and clinicians.

—In a letter from a Colorado correspondent to an American contemporary, the writer propounds this question to the editor: "You will not object to my asking you whether you served in the cavalry branch of the service during the late unpleasantness?" and answers it himself, "I don't believe you did, because you wrote the article upon *Equitation as a Preventive and Cure in Hemorrhoids;* not but the article has many good points—only cavalry men do have piles."

CANADA

MEDICAL & SURGICAL JOURNAL

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Original Communications.

ABSTRACT OF A CLINICAL LECTURE ON POTT'S DISEASE OF THE SPINE, WITH PSOAS ABSCESS.

By T. G. RODDICK, M.D.,
Professor of Clinical Surgery, McGill University; Surgeon to Montreal General Hospital.

(*Delivered during the present session.*)

GENTLEMEN,—The case I present to you to-day is one of more than ordinary interest. Our little patient is about seven years old, and, as you will readily notice, is thin and anæmic. The parents are fairly healthy people, and have had a large family of strong children, this being the youngest. They state, however, that this child has always been delicate, and has been complaining of odd symptoms for the past five or six months, although it was not thought necessary to seek professional advice until the present time. For the past two or three weeks the child has been walking about in a stooped position, and seeming to favor the left leg, but not till a day or two ago was any notice taken of this lump which you see in the groin. Nothing unusual about the back has ever been seen by the friends, although we find a distinct prominence of the tenth or eleventh dorsal vertebra. There is no pain elicited by pressure over this, as the child stands, but when I place him across my knees, and extend the spine, you will notice then that he winces when I reach that part with my finger and thumb pressing on the vertebræ. I might mention that a hot sponge or piece of ice drawn slowly down the back will sometimes detect disease when pressure fails, and espe-

cially is this the case when no deformity has yet occurred. You will often notice, also, that if you extend the spine by separating your knees in this fashion, the child lying across them, you give great relief, as the diseased surfaces are kept apart for the moment. I pointed out to you, on a former occasion, that the grunting respiration, which is often so remarkable in cases where the disease is higher up, at once ceases when this method of extension is practised. I would caution you, however, against too forcible extension, as dislocation of the bones and irreparable injury to the cord might readily occur.

The case, then, is one of angular or antero-posterior curvature, or Pott's disease of the spine. But has the swelling in the groin anything to do with the back trouble? The gentlemen, whose turn it is to diagnose, are of the opinion that this is a psoas abscess, and hence that the two conditions are directly connected. Let us get at the truth by that admirable process of exclusion. We think it is not hernia, because we find the femoral vessels to the inner side of it; besides, it fluctuates, and when the child is put in the recumbent position it gradually subsides, to return as gradually when he is made to stand again. It is well to examine the condition of the hip, because we know that in a small percentage of cases the bursa of the conjoined tendon of the psoas and iliacus muscles has a direct communication with the capsule of the hip joint, and in abscess of the latter, the pus will, perhaps, appear first in this very situation. There seems to be nothing wrong with the hip joint. I think we can readily exclude other conditions, such as glandular or fatty tumors, soft cancer, pelvic abscess, &c. The pus of an empyema has been known to find its way behind the diaphragm, and into the psoas sheath, making its presence known for the first time below Poupart's ligament. I think, then, there can be no two opinions about the nature of this swelling; but in order that there may be no mistake, we will use this valuable little detective, the hypodermic syringe, which at once demonstrates the presence of pus.

Now comes the important question, how can we best treat this case? Many of you would naturally recommend that the abscess

should be opened immediately, and that the curvature could be attended to subsequently. I prefer, however, to reverse that order of procedure, and to support the back before touching the abscess, and for this reason : The pus here present in the sheath of the psoas muscle is acting as a sort of splint to the diseased vertebræ, and if we remove this before providing some equivalent support, the weight of the body above, coming suddenly to bear on the carious bones, may do incalculable mischief. We will, therefore, first apply Sayre's plaster of paris jacket, and then open the abscess.

You will notice that we suspend the patient while applying the bandages. Many surgeons, and among them I find my friend Mr. Edmund Owen of St. Mary's Hospital, London, have entirely discarded this part of Sayre's apparatus, and adapt the bandages with the patient simply standing before them. Sayre teaches that when a person with this disease is suspended, the angle of curvature is considerably reduced, and that this is the case, to a slight extent, I have no doubt; indeed I have seen him demonstrate the fact. But is this improvement in the condition of curvature lasting? Mr. Owen thinks not, and hence he has discarded the tripod. I am also of his opinion, after having had some considerable experience with the method, but I still employ suspension in a way, because I find that if the straps be properly and evenly adapted, and if the patient be supported rather than suspended, he can often bear the application of the bandages with less fatigue than if required to stand unsupported. I fail to see what advantage the "hammock method" of applying the jacket has over this, excepting in the case of a very weak or nervous person.

The jacket having been now applied, we will turn our attention to the abscess. In some of the text-books you are advised to be in no hurry about opening a psoas abscess, and it is often a difficult question to decide exactly when to interfere. If, however, the abscess is rapidly increasing in size, and has reached the dimensions of a goose's egg below Poupart's ligament, as in this case, then there can be no doubt of the advisability of opening it. Now, how can we best give exit to this pus? Of course the

simplest plan of all is to plunge a bistoury into some part of the swelling, and allow the pus to flow out, taking no heed to the entrance of air. But I think we can do better than this for our patient. If we allow air to enter, we will almost certainly have putrefaction, and, perhaps, subsequent blood contamination ; and I think you will agree with me that no surgeon is justified in subjecting his patient to such terrible risks. If we can succeed in excluding the air for a few days even, then the dangers from this source will rapidly diminish. We can open the abscess under water, containing at least one per cent. of carbolic acid, and in that way exclude the air. This may be done either by sitting the patient in a bath or other vessel containing sufficient of the solution to cover the part thoroughly, and then open in the ordinary way, taking the precaution to guard the wound with a carbolized pad, backed with another large pad of oakum, and held in position by a firm spica bandage. A drainage tube should be introduced while the incision is still under water. Another plan is to attach a rubber tube to a large-sized aspirating needle, fill the whole with carbolic solution, puncture the abscess, and drain away the pus under the surface of the water. Or, should you possess the ordinary Dienlafoy's aspirator, use it, and in private practice it looks less horrifying than the knife. As I see one on the table here, we will attempt to empty this abscess with it. You will notice that I do not plunge the needle into the thin part of the sac, but prefer introducing it, as you saw me do in the case of meningocele the other day, at about three-quarters of an inch from the margin of the sac, my reason for this being to prevent subsequent leaking of the abscess contents and the inevitable ingress of air. I think this is a wise precaution to take in the case of all abscesses or cystic growths treated with the aspirator. I find, however, that the pus, probably of the curdy kind, refuses to flow through the needle, which, by the way, is no exception to the generality of aspirating needles—namely, in being too small. Having failed with the aspirator, then (and I am not sorry in one sense, because the relief could have been only temporary), we will proceed to treat the abscess, as we prefer to do with all such cases in this hospital, namely, with

strict antiseptic precautions, as laid down by Lister. Now that the spray of 1 to 40 is playing fairly on the part, and our hands and instruments are carbolized, we will make an incision with the ordinary scalpel at the most dependent point, which, here, is the lower and outer margin of the fluctuating spot. With the director we tear through the fascia, and you notice the enormous quantity (over an imperial pint) of fairly healthy, but somewhat curdy, pus which is flowing out. In order to drain the cavity thoroughly, we will introduce about four inches of this medium-sized tubing, with the safety-pin attached to its mouth to prevent it from slipping through the incision and being lost within. We need no protective in this case, but will apply an unusually large amount of gauze, in order to absorb the pus, as we hope not to be obliged to disturb our little patient again for three or four days.

AN INVESTIGATION INTO THE PARASITES IN THE PORK SUPPLY OF MONTREAL.*

By WM. OSLER, M.D., & A. W. CLEMENT, Veterinary Student

In the interests of public health, it is a matter of great importance that the food supply of cities should undergo strict supervision, with a view of excluding possible sources of disease. In this country, the department of the civic governments relating thereto cannot be said to be conducted on model principles. Speaking of Montreal, meat inspection consists in the examination of the carcasses of all animals exposed for sale or killed at the abattoir, and its superficial character is clearly shown by the results of this investigation.

It is to be remarked that, in the matter of meat inspection, there are some affections in which an ante-mortem examination will be of most service, and an animal may be condemned as unfit for food, the meat of which, when dressed, might pass even a careful inspector. There are other affections which, interfering but slightly with the general healthfulness of an animal, render its flesh in the highest degree unfit for food, even though it may, on superficial inspection, look healthy enough.

*(*Read before the Medico-Chirurgical Society of Montreal and the Board of Health.*)

The flesh of swine forms one of the great staple articles of food in the community, and, fresh or salted, constitutes a very considerable proportion of all meat eaten. The hog is omnivorous, a dirty feeder, refusing nothing, and, regarded from this standpoint, we do not wonder that in the sanitary enactments of Moses it was excluded, though cloven-footed, in the list of animals permitted to be eaten. Vile feeder though it be, the hog has the power of converting, in the laboratory of its tissues, even refuse and garbage into a flesh most wholesome as well as toothsome. Who does not remember Lamb's charming "Dissertation on Roast Pig," and though he speaks of the suckling, most of us can agree with him when he says, "Pig—let me speak his praise—is no less provocative of the appetite than he is satisfactory to the criticalness of the censorious palate. The strong man may batten on him, and the weakling refuseth not his mild juices."

The hog is not subject to many diseases which interfere with the market value of the flesh. Pig-typhoid or hog cholera is the only extensive epizootic disease among them in this country, and by interfering with nutrition and producing emaciation renders the flesh unsuitable for food. The injurious effects which follow the eating of the flesh of diseased animals are really not much known. The juices of the stomach are so powerfully antiseptic and corrective, that the meat, after cooking, is usually digested without difficulty. The Highland shepherds are stated to eat, without ill effects, the flesh of animals which have died of anthrax. In the case of pork, it is not so much the fresh or salted meat which has been known to produce sickness as when it is made into sausages and brawn (head cheese). Many cases of serious illness have been excited by eating these articles. This is not surprising to anyone who has watched their manufacture, particularly sausages. In many establishments the odds and ends go for the mince meat, and, too often, bits of old meat which is just beginning to turn. The experience is only too common of tasting in a mouthful of sausage the disagreeable flavor of a morsel which is high, *i.e.*, is in the initial stages of putrefaction. The septic matter, if abundant, or, perhaps, if produced by bacteria of a special variety, may excite severe intestinal symptoms, and even

cause death. In Whitechurch, England, there has recently been a local epidemic produced by eating brawn.

In relation to public health, the diseases of the hog are of small matter in comparison with the parasites which infest its flesh, and which, eaten by man, may produce serious or even fatal affections. It is as a protection against these that an effective meat inspector may do good service in the community, and annually prevent many cases of illness. To obtain evidence of the prevalence of parasites in the pork supply of this city, one thousand animals have been examined, with the results here stated. Of the parasites which infest the hog, only three are of importance in this connection—the *Trichina spiralis*, the *Cysticercus cellulosæ*, and the *Echinococcus*. We shall consider these in order.

TRICHINA SPIRALIS.

"An extremely minute nematoid helminth, the male in its fully developed and sexually matured condition measuring only one-eighteenth of an inch, while the perfectly developed female reaches a length of about one-eighth of an inch; body rounded and filiform, usually slightly bent on itself, rather thicker behind than in front, especially in the males; head narrow, finely pointed, unarmed, with a simple, central, minute oval aperture; posterior extremity of the male furnished with a bilobed caudal appendage, . . . female shorter than the male, bluntly rounded posteriorly, eggs measuring $\frac{1}{12}\frac{1}{70}$ of an inch from pole to pole; mode of reproduction viviparous." —Cobbold.

Since Zenker, in 1860, discovered that this worm produces a severe malady in man, a degree of interest has been attached to it, not exceeded by any known human entozoon. The record of epidemics of it sends a thrill of horror through a community out of all proportion to the gravity of the disease; and naturally enough, for the very thought of myriads of these little worms boring and eating the flesh is particularly repulsive, recalling the tragic fate of Herod, on whom the worms are stated to have held an ante-mortem feast. The hog is the natural bearer of the trichinæ, which exist in the flesh, coiled up between the muscle fibres, and are so minute that they cannot be seen on ordinary inspection, but require the use of the microscope. In this state they are undeveloped or immature sexually, and may remain for years in the muscles of the animal without undergoing de-

generative changes. Pork containing them and eaten raw, in any form, or partially cooked, produces disease in the following way: the little worms escape in digestion, pass into the small intestines, grow rapidly, become sexually mature, and assume the form of intestinal trichinæ. The females are impregnated, and the ova develop into minute embryos, which are born alive and free. This process occupies two or three days, and is usually accompanied with some intestinal irritation. The number of embryos will vary with the number of worms ingested and which reach maturity. They immediately burrow through the walls of the intestine, reach the connective tissues of the abdomen, and penetrate the muscles in all direction, and when numerous reach even those most distant. In this migration they produce irritation, fever, and constitutional disturbance proportionate to their number, and the severity of the symptoms may be such that death may follow, though the percentage of fatal cases is small, only about 1.5.

Record of Investigation.—One thousand hogs were examined, chiefly at the Dominion Abattoir, during the past six or eight months. There was no selection made, but the carcasses were taken indiscriminately, as they were found at the time of the visit.

Method.—It has been satisfactorily shown by many observers that the pillars of the diaphragm are the most suitable muscles for examination, not alone because portions can be removed without disfigurement or loss, but chiefly from the fact that here, if anywhere in the body, the parasites will be found, as these muscles lie in the direct route from the intestines. The examination was made with No. 2 Obj. (Verick) and No. 1 Ocular, magnifying about 60 diameters. Small clippings of the muscle were made lengthwise, then placed on the slide, and pressed out with the top cover until thin enough for the purpose. In only four out of the one thousand animals were the parasites present in the diaphragm, and we may take this as representing the actual ratio, though possibly they may, in one or two instances, have existed in other muscles and not in the portions examined. As to the number in the infested bits, in one case there were twelve on one

slide; in the others, not so numerous. The worms were not regularly encysted but coiled up between the fibres. When placed on the warm stage, they displayed movements.

All the animals examined were from Western Canada.

Comparison of local with foreign records.—As the following figures show, the record here, 1 in 250, is by no means high. Thus, in Boston, Mr. Billings examined over 6,000 animals, and in the different groups the ratio ranged from 1 in 17 to 1 in 44. All of these animals were from the Western States. In Chicago, one series gave 1 in 49.8. In Prussia, where a very thorough and systematic pork inspection is carried out, in the year 1876 only 1 in 2,000 was found affected, and in 1877 about 1 in 2,800.

Trichinosis in Canada.—Remarkably few cases of trichina infection are known to have occurred in this country. In 1869 nine persons were attacked in Montreal after eating of fried ham, which was ascertained to be trichinous. They presented severe gastro-intestinal symptoms, and the constitutional disturbance in moderate grade. None of them died. The diagnosis was corroborated by the microscopic examination of a portion of muscle harpooned from one of the patients.* In 1868, three members of a family in Hamilton were attacked after eating portions of an infected ham. Two of these, the mother and daughter, died; the father recovered. At post-mortems and in the dissecting-room, it is not uncommon to find the muscles full of calcified cysts containing the worms or their remnants. These little bodies had been recognized for years before Zenker's discovery connected them with an antecedent disease. Probably many isolated cases occur which are mistaken for acute rheumatism or typhoid fever. In between 800 and 900 autopsies made by Dr. Osler, four bodies have been found trichinous, the cysts in each instance calcified, and in one the worms were nearly all dead. In the other cases the parasites were still living, and with muscle from one of them the disease was artificially produced in a rabbit. So that in all only sixteen cases of the disease have been recognized in this country.

* *Canada Medical Journal*, 1870.

Summary.—So far as it is legitimate to draw deductions from the somewhat limited number of observations, we may say that trichinosis is a tolerably common affection in Canadian swine, though not nearly so frequent as in the neighboring States, still, it is much more so than is desirable in the interests of public health. Should microscopic examination of the flesh be included in the inspection? is a question which at once arises. In answering this, several circumstances must be taken into consideration. In the first place, although, per 1,000, a larger number of swine are infested here than in Germany, trichinosis in man is with us a very rare disease, while in Germany epidemics are of yearly occurrence. If we estimate that 100,000 hogs are killed annually for the local markets, that would give at least three or four hundred trichinous animals, whose flesh is consumed by the pork-eating members of the community. Then, about $3\frac{1}{2}$ million pounds of American pork, representing about 15,000 hogs, have been imported into this city during the past year, and as in them the percentage of trichinæ is considerably higher than in Canadian animals, the probable number of infested carcasses consumed does not, at the lowest estimate, fall short of five hundred. Now, were the habits of the people of this city similar to those of the Germans, there can be no doubt that trichinosis, instead of being a rare affection, would be extremely common. Fortunately, raw or only partially cooked pork is not often eaten here, nor are the various kinds of sausages, so dear to the Teuton, much in vogue. *Knackwürste* and *Bratwürste*, forms of sausages which are very common, and which are eaten either raw or only warmed, have been the sources of a large proportion of the known cases of trichinosis in Germany, 970 out of 1,267. People here almost invariably fry sausages, and smoked meats are not common, nor are they eaten without preliminary cooking. In short, the prophylaxis of the pot and oven in this country and in the neighboring States does more for the public than the most stringent inspection, even as carried out in Prussia, where a microscopic examination is compulsory. If thoroughly cooked, the trichinæ are killed, and may be eaten with impunity; and, fortunately, there is a very widespread idea in the community that pork, in

all forms, should be well cooked, and to this good custom may be attributed the immunity from infection which the public has enjoyed. Still, it is by no means pleasant to think of the quantity of trichinous flesh which is placed on our markets, and which probably exceeds the entire amount of pork confiscated for other causes. The difficulties in the way of systematic inspection are now, under the Abattoir By-law, greatly lessened, but to subject the flesh of every hog killed to microscopic examination would require a staff of trained inspectors and an increased expenditure such as our civic authorities would not likely incur. Moreover, considering the rarity of cases of infection, it may be just as well to leave the matter to the cooks of the community, who have so long and so faithfully protected us, with this injunction, "See that all pork is thoroughly roasted, fried, or boiled."

CYSTICERCUS CELLULOSÆ.

This parasite of pork is not so formidable as the trichina, but is more common and a more frequent excitor of disease. It is the larval or immature form of one of the tapeworms of man, and is popularly known as the "measle" or cystic worm, and an infested animal or its flesh is said to be "measley." In this country man is infested with two chief forms of tapeworm, the *Tænia solium* and the *Tænia saginata*—the former derived from measley pork, the latter from measley veal or beef; hence the one is often called the *pork* and the other the *beef* tapeworm. The life history of the *Tænia solium* is as follows:—the adult worm occupies the small intestine of man, and attains a length of from 12 to 15 feet, or even longer. The segments of which the body is made up progressively increase in width from the head, and about the 400th become mature—*i.e.*, the male and female generative system which each possesses becomes active, and eggs are formed. In a fully grown worm it is estimated that there may be about 200 ripe segments full of ova, the number in each one reaching probably as high as fifty thousand. The hinder segments of a tapeworm are constantly shed, or, indeed, may detach themselves, at the rate of 3 or 4 per diem, and pass away in the fæces. The eggs are small, round, $\frac{1}{700}$ of

an inch in diameter, and each one contains in its interior a little body known as the six-hooked embryo. For their further growth it is necessary that they reach the interior of some animal in which they can develop. The hog is the most suitable, and usually furnishes the means for the subsequent growth of the ova, though the eggs may be accidentally ingested by man and develop within him, but this rarely happens. It is not difficult to understand how hogs become infested; they are such dirty feeders that nothing is refused, and even human excrement is greedily eaten. In country places, a single case of tapeworm may serve to infest many hogs, as the ripe segments constantly pass with the fæces, and one or two will suffice to produce the mischief. The eggs in the stomach of the pig are digested, and the little six-hooked embryos, in this way set free, immediately begin to bore through the walls, and, entering the vessels, are carried to all parts of the system, lodging particularly in the liver and muscles; others pass through the coats of the bowels into the peritoneum and omentum, and may reach the muscles in this way. In these various parts the little embryos gradually develop into cysticerci or "measles," and an animal so affected is said to be measled. It takes about three months for this process, and when completed, the cysticerci present the appearance in the flesh of greyish-white rounded bodies from one-tenth to one-sixth of an inch in diameter, situated between the fasciculi of muscles, and can be picked out, leaving little holes or depressions. When abundant, they give a very characteristic aspect to the flesh, which is quite unmistakeable. In the liver they may attain a larger size, and in the loose tissues of the omentum and peritoneum they are often found the size of a walnut. The cysticercus or measle is enclosed in an external sheath, which, when open, gives exit to a cystic or bladder-like body, which requires careful dissection to make out the structure. It presents a head similar in all respects to that of the adult tapeworm from which the egg was derived, presenting four sucking disks and a circlet of hooklets. A narrow neck succeeds the head, and beyond this there is a bladder-like body called the caudal vesicle.

If flesh containing these "measles" is eaten raw or only partially cooked, tapeworm is liable to result. The cyst wall enclosing the cysticerci is digested away, the bladder worm set free, and passes into the intestine, where the head fixes itself firmly by means of the sucking disks and hooklets. The caudal vesicle is digested away, and by a process of budding the segments are gradually formed. In about two months the worm has attained maturity, and segments are discharged containing thousands of eggs, ready for development in the body of the first pig that accidentally ingests the segments.

Local Record.—Of 1037 hogs examined, 76 were infested—*i.e.*, 1 in 13.6. Only the livers were inspected, as it was impossible to examine the flesh thoroughly. The numbers varied from one or two to many dozen, and in most instances they were fully developed. The liver is more likely to be affected than the other parts, but the occurrence in this organ is a proof that the animal has been exposed, and should lead to a thorough examination of the flesh.

In order to obtain evidence of the extent to which "measled" meat produces disease—*i.e.*, tapeworm—in the community, we issued a circular to the city physicians asking the number of cases under treatment. Replies were returned by thirty-four doctors who reported sixty-two cases. At the Smith Worm Company's office, Bleury Street, about two new cases a week are treated; some of these, doubtless, come from the country, but we shall probably be within the mark if we estimate the number in the city as not far short of 200. How many of these are due to eating measley veal or beef, and how many to measley pork, we cannot say, but from the specimens examined it would seem that the beef tapeworm (*T. saginata*) is the more prevalent. Not that the pork measle is uncommon; the record above given shows just the contrary. To explain the greater frequency of *T. saginata*, we must suppose either that the beef measle occurs in greater proportion, or else the pork is more thoroughly cooked than the beef or veal. Then, too, much less pork is eaten fresh, and the salting and pickling processes are usually sufficient to destroy the measles. A point of in-

terest is the temperature necessary to kill them. The observations of Professor Perronicito prove that they are invariably killed by a heat of 50°C. or 122°F. Indeed they were swallowed with impunity by his students after exposure to a temperature of 113°F.

Fortunately, the presence of a tapeworm does not give rise to such a formidable affection as the trichina, but the amount of suffering and annoyance caused is considerable, and not infrequently an individual has to entertain the troublesome host for months or years, so difficult is it in some cases to dislodge the worm.

A thoroughly efficient inspection would diminish greatly the number of persons annually infected. Of course a hog might contain only a few "measles" deep-seated in the muscles, and these could readily be overlooked—indeed would be even on the most careful examination.

ECHINOCOCCUS.

The presence of this parasite in the flesh of pork has not the direct and close relationship to our individual welfare as the trichina or cysticercus, inasmuch as it represents a larval form of a tapeworm which infests the dog and wolf—never man. The adult worm is very small, not more than a quarter of an inch in length, with only four segments, the anterior of which forms the head, while the hinder one is mature and contains the ova, which are passed in the fæces of the dog, and if swallowed by an animal may develop in its organs or tissues into the structures variously known as echinococci, hydatids, or acephalocysts. A single egg of an ordinary tapeworm, when placed in suitable circumstances, develops into a single larva or measle (*cysticercus*), but a remarkable peculiarity in the life history of the *T. echinococcus* is that a single egg develops into a large compound and complicated cyst, which contains many thousands of larvæ—hydatids or hydatid heads, as they are called—each of which, if transferred to the intestine of a dog, might grow into a tapeworm. Man also harbors the echinococci, which may produce very serious or fatal disease. In some countries, as Iceland and Australia, this affection is very prevalent, and many deaths are annually caused by

the growth of the hydatids in the internal organs, in which they may form large tumors. Man gets infected in the same way as the hog by the accidental ingestion of the ova, and the point of special interest, in relation to public health, is that the occurrence of echinococci in the hog—and in other animals—ensures a constant perpetuation of the species among the dogs of a community and a consequent risk to the individuals thereof, which will be great in direct proportion to general insanitary condition and the liability of the eggs to get into the drinking water.

Result of Examination.—In the 1,037 hogs examined, echinococci were found in the livers of 31, or 1 in 33.4. The cysts ranged in size from a marble to a walnut, and presented an external fibrous investment, formed from the tissues of the part, within which was the cyst proper, which could be readily turned out. The ectocyst and endocyst were usually well developed, the fluid clear, but in none of those examined microscopically were the hydatid heads fully developed.

Echinococcus disease in man is in this country a very rare affection; not more than eight or ten cases have been known to occur. In the United States it is also uncommon,* and a considerable number of the reported cases have been in foreigners, who probably brought the parasite with them. The immunity from the disease which human beings here happily enjoy may be explained by the existence on the whole of such sanitary regulations as reduce to a minimum the risk of infection. Dogs are not numerous, nor are they so intimately associated with the every-day work of the people, as in countries like Iceland, where, according to Krabbe, the ratio of canine to human population is very large, and an extraordinary number of the inhabitants suffer from the affection. The adult worm is certainly rare in our dogs; we have never met with a specimen in numerous dissections, but its existence is fully shown by the occurrence of the larval form in many animals and occasionally in man.

* On Echinococcus Disease in America, by Wm. Osler, M.D., *American Journal of Medical Sciences*, Oct., 1882.

CONCLUSIONS.

1. The investigation shows that the hogs slaughtered for our markets present parasites in numbers sufficient to necessitate a more thorough inspection than is at present carried out.

2. As regards *Trichina spiralis*, which was found in the proportion of 1 to 250, we are of opinion that, considering the extreme rarity of cases of trichinosis, and the difficulties attendant upon a systematic inspection, a compulsory microscopic examination of the flesh of every hog killed is not at present called for.

3. In the case of "measles," the liver should be carefully examined, and if present in it, the flesh of the animal should receive the special attention of the inspector; if only in the liver, the entire carcass need not be confiscated.

4. Echinococcus cysts in the liver render that organ unfit for food, but in other parts, unless very numerous and disorganizing, they may be cut out, and the carcass remain marketable.

5. The public should be made aware of the possible dangers of eating, in any form, raw or partially cooked meat. The best safeguard against parasitic affections is not so much inspection of the flesh, unless, indeed, this is minutely carried out, as careful attention to culinary details.

6. To reduce the number of infested hogs, greater attention should be paid to their hygienic surroundings, particularly in the matter of feeding. The danger is not during the period when the animals are penned and fed on grain, &c., but when they are allowed to roam at large and feed indiscriminately.

Our thanks are due to the authorities of the Montreal and of Dominion Abattoirs who kindly permitted the inspection.

A TRIP TO COLORADO—NOTES BY THE WAY.

By T. WESLEY MILLS, M.A., M.D., Montreal.

Any conclusions based upon a trip extending over three weeks must necessarily be open to objection; still, it has occurred to me that a few notes such as I was able to make might not be without interest to some of the readers of this Journal.

First of all, with respect to means of travel, I found the journey from Montreal to Chicago by the G. T. Railway by far the most

undesirable, and, on the return trip, took another route in preference ; but, as a gentleman observed, one scarcely knows what railroading is till he gets beyond Chicago, so superior is the management in all respects. An invalid with a compartment in a Pullman, or, better still, a " drawing-room," will cover these great distances with unexpected comfort and ease. The journey from Montreal to Denver by the fastest possible travel may be set down at about three and a half or four days. Of course, an invalid ought not to attempt to cover two thousand miles in that time, especially as great changes in altitude are made. It may be remarked, too, that the dining cars attached to trains furnish meals that are all that is claimed for them ; indeed, equal to those of a first-class hotel.

During a brief stay in Chicago, I visited the new College of Physicians, open this year for its first session. Dr. Angear, Professor of the Principles of Medicine, with characteristic American courtesy, showed me every part of the building. The edifice is an unusually handsome structure, of light-colored stone, with polished dressings, and of three storeys. Its principal lecture-rooms are very large and well-lighted, with an easy access for students by different entrances that must prove a great convenience. But the absence of any sort of desk or support for note-books in so perfectly arranged a building seemed to me remarkable. The laboratories were not quite completed, so that any special excellencies they may eventually possess were not yet developed. The building is supplied with two hoists—one for use by the professors ; the other for students, subjects, &c. These are of the greatest service, and it is contemplated to bring up from the ground-floor a patient lying on a couch, when desirable for clinical instruction. Each professor has a private-room, with his name on the door. The lecturer on chemistry has a counter on which he can, in his laboratory, place his various chemicals, &c., and then shove forward on the truck provided for it to his lecture-room, evidently a most desirable arrangement. In the basement I was shown a large *refrigerator*, specially constructed to preserve subjects. On the ground-floor the various departments of the Western Dispensary, really the College's

own, are located. The doors of the various rooms are labelled to indicate the class of diseases to be treated therein, such as "Diseases of the Chest," "Diseases of the Eye." "Diseases of Women," &c. From certain other provisions, it was perfectly clear that the students had been considered in other aspects than as mere students. In the basement there is a *dining-room*, where meals may be had at a cheap rate. There is also a neat little office where enquiries can be made of the secretary, and where a student can, by an easy method, ascertain whether there is any mail matter for him, and, if so, obtain it. A third matter of interest was a superb drinking fountain. In some schools the ordinary water-tap, with an old and battered tin cup, is made to do duty. I must confess I was myself particularly pleased to see this College built with so much regard to the elegant and beautiful. It does not seem unreasonable to expect a young man who may here spend his whole career as a student, amid beautiful and agreeable surroundings, to be the better prepared to act the refined and polished gentleman society expects the doctor, even the young doctor, to be. If everyday experience teaches anything, it is the value of surroundings in moulding the character. I left this College feeling that if they devote as much attention to the training of their students, and in getting the right sort at the commencement, as they have in providing a most beautiful and suitable edifice for their reception, it will have but few rivals. Before the structure was begun, the architect was directed to visit several of the principal schools in America with a view of getting the latest and best ideas. I did myself the honor of calling upon a graduate of McGill, Dr. St. John, who is a professor in this College, and whose name appears on the foundation-stone as one of the original founders. The doctor made several inquiries of me in regard to his *Alma Mater*, evidently with a view of ascertaining whether she was falling behind, keeping abreast, or leading the times.

But to leave Chicago with its damp and raw atmosphere we were glad to escape from, and get to the broad plains of Kansas, Missouri, &c. We did not begin to feel the effects of altitude till within four or five hours ride of Denver, perhaps because we

aarived at that city about 10 A.M., and sleep before the hour of six had made all things as though they were not to us. But about 7 A.M. I noticed that a young lady of robust health, and with a florid complexion, seemed to be unusually flushed in the face, and complained of a sense of fulness and headache. This sense of fulness I myself experienced, and noticed a slight tendency to epistaxis.

Denver is a magnificent city, and has some features suggesting a degree of progress perhaps not equalled by any city in Canada. It is "the hub" of the far west. It was a great pleasure to meet here Dr. E. A. Rogers, a graduate of McGill of '80; and, later, Dr. Bonesteel and Dr. Cattanach, also graduates of McGill; and being so far from the old place, we clanned together like "John Tamson's bairns," for which, under the circumstances, it is hoped we were none the worse. From all the medical men I had the good fortune to meet, I gathered as much as possible relating to the climate. Dr. Rogers has been but one year in Denver, and would not give dogmatic assertion to his opinions. Dr. Bonesteel, like myself, was a visitor, though a delighted one, to this part of the country. Dr. Cattanach has sought this climate for a lung affection he himself has, as will be known to many. Dr. C. has travelled over almost every part of this continent. Some weight, therefore, must be attached to his opinions. He said: "There can be no doubt that this is *the* climate for consumptives, but it is a mistake, I think, to send all patients to Colorado Springs. The air of the more northern part of the State is more bracing; people can take more cod-liver oil there." He added, as did other residents, "the locality that suits one does not always equally well, or at all seasons of the year, suit another.

I also called upon Dr. Dennison of Denver, well known for a work he has written on Colorado as a health resort. I regularly "interviewed" the doctor, and put a good many questions to him. Perhaps I may summarise the views he expressed as follows: There are a good many cases of phthisis that Colorado climate will not only not cure, but will make rapidly worse. These are: 1st, Cases of disseminated tubercle. 2nd, Cases of acute

tuberculosis. 3rd, Cases in which there is little healthy lung left. Indeed, all the physicians there lay stress on there being a portion of lung quite healthy,—*enough for the patient to live upon till he can get the benefits of climate for the diseased part.* Cases of bronchitis are often made worse; cases of asthma are almost unknown in Colorado. Hemorrhagic cases, provided they bear the first effects of the change of climate, do well always. The patients do not take on the hemorrhagic character in Colorado. He observed that he was glad to know that our Professor of Practice of Medicine agreed with him in regard to the advisability of leaving *fistula in ano*, in phthisical patients, alone. Dr. Dennison thinks small cavities are often overlooked, and showed me a double stethoscope, with a very large bell, he uses for their detection, by holding it before the patient's mouth during percussion. Finally, Dr. D. thinks that if patients do not improve within the first four or six weeks, but, on the contrary, fail, it will be useless for them to remain. He complains, as do other Colorado physicians, that patients are sent out without due discrimination as to the sort of cases, and he often advises them to return at once, so that they may die at home.

I visited and spent a very short time at Canon City, Pueblo, Colorado Springs, and Manitou. At Canon City, a very pleasant interview with Drs. Dawson and Gray took place. Dr. Dawson spoke of a well-known medical neighbour of mine in Montreal, who, on his arrival there, looked like a "cadaver," but, after a few months residence, returned to Montreal to resume a large practice, and now enjoys good health. I can never forget the manner in which the clear, bright, invigorating, yet balmy air of Canon City impressed me. Sheltered as it is on three sides by mountains, with its two excellent springs (one a gas spring, the other an iron spring), it seems to me to possess, from a climatic point of view, certain decided advantages over Colorado Springs and other places often chosen. It is a few degrees warmer than Colorado Springs, and more sheltered from winds; though the Springs people say its dust is of unrivalled quality of badness. But the dust is a nuisance everywhere in Colorado—indeed so bad at times even in Denver, that people keep within doors.

Colorado Springs is a pretty little town; evidently, as far as society and culture are concerned, the place, of all others, among health resorts in the State. The medical talent here is also first-class. Dr. Bull, one of McGill's *alumni*, ranks among the best men. Dr. Solly, who paid a short visit to Montreal a few months ago, is the author of some very carefully written monographs on the climate of Colorado and on the mineral springs of Manitou. A very great want is being now supplied, so that by next spring Colorado Springs will have a really first-class hotel, which it has not now.

Manitou is a delightful little spot, nestling among the mountains, about six miles from Denver, is now accessible by rail, and with its hotels, its springs, its baths, its greater elevation, must furnish a most desirable resort, in summer especially. One quality of the climate of Colorado has not become generally known, I fancy, and that is, its power in *improving the digestion*. All the medical men agree that acute nervous diseases are made worse in this climate. Pueblo is a good smelling centre, and unsuitable as a residence for an invalid. My own general impression of the climate may be summed up about as follows: In those cases where climate can avail at all, the climate of Colorado is that which has all the conditions any climate can have to assist in the cure of pulmonary diseases, but that the greatest care must be exercised in the selection of cases. Many persons will find it necessary to become permanent residents. There is abundant evidence to show that if Colorado climate does not agree, it will not answer to change for a more southerly one, as to go to that of California. Considering the great distance, the expense, and the separation from friends, I would suggest that in doubtful cases it would be well to have a consultation, by letter, with some reliable resident physician, giving all the details of the case, before sending the patient off. Moreover, in most cases it would be wise to take some steps to secure comfortable quarters before setting out, for it is hard enough for one in health to get those in the little towns I have mentioned, and how much more so for an invalid.

As I write not as a tourist, but a physician, I say nothing of the scenery of this country, which is of unrivalled grandeur.

CASE OF IDIOPATHIC TETANUS.

TREATED BY CHLORAL AND POTASS. BROMID.—RECOVERY.

By C. L. COTTON, M.D., Cowansville, Que.

E. C., æt. 6, of good family history and generally good health, complained on October 27th of some soreness in the jaws, which was attributed to a slight cold or to mumps, which disease was prevalent in the neighborhood. He ran about all day, but during the night it was noticed that he was more restless than usual, and groaned in his sleep. The following day, while putting on his shoes, he complained to his mother that the act of bending over hurt his back. His mouth was sore, for which some simple remedy was prescribed, and he was confined to the house and given a dose of castor oil. His appetite did not fail him. Towards night he experienced some difficulty in opening his mouth, and there was a slight swelling at the sides of the jaws, which confirmed his parents in their opinion of the case being one of mumps. Also, during the evening, he complained of some pains in his back. On the 29th, his right leg was stiff, and he walked with difficulty, and continued to complain of pain in his back. His mouth, it was noticed, could not be opened to its full extent. His back and left leg showed signs of becoming stiff. During the night the pains in his back and legs became more frequent, almost entirely preventing sleep. On the following day, all his symptoms increased in severity.

Oct. 31*st.*—Was called to see the boy to-day. I found him lying on his back, with considerable rigidity of the body and legs. The legs could be partially flexed at will, but with difficulty. Mouth could be opened about three-quarters of an inch. Tongue heavily coated, and numerous spots of aphthæ about the mouth. He complained of sharp darting pains in his legs and abdomen, sometimes referring them to the region of the stomach and sometimes to the lower part of the abdomen. During these pains I noticed slight contraction of the muscles of the legs, just enough to give him a sudden start. The pains recurred every five or ten minutes. Pulse, 120; temperature, 101°F. Appetite good. Constipated. Ordered Hydrarg. cum Creta, grs. v; Pulvis Rhei, grs. x; followed in four hours by castor oil; afterwards Tr.

Aconite ♏i hourly; diet, milk and broths. Believing this to be a case of Tetanus, I enquired very particularly regarding the past month, but could find no history of injury whatever. The day before his first complaints were heard he had been out three or four miles on a cold day, and not very warmly clothed. On his return home he complained of being very cold, and this fact is all I could discover bearing on the case.

Nov. 1*st.*—Had a very restless night. Kept awake as on the previous night by the spasmodic pains, but says he is freer from pain this morning. Pulse, 122; temperature, 105.5°F. Rigidity of all the affected parts increasing. Ordered Potassii Bromid. grs. x every three hours.

Nov. 2*nd.*—Pains were very severe during the night, causing much suffering. Referred the pains altogether to the region of the epigastrium. Back is becoming arched. Head thrown back. The entire body, except the arms and face, is quite rigid. The feet are extended to their utmost limit, and toes bent inward.

Nov. 3*rd.*—Another sleepless night, with very profuse sweating. Spasms in all the affected muscles were very frequent, but only of momentary duration. Neck, trunk and legs absolutely rigid. Opisthotonos well marked. The teeth can still be separated about half an inch, but the jaws are affected like the rest of the muscles by the spasms, and he has bitten his tongue several times. Takes nourishment well. Some difficulty in passing water.

Nov. 4*th.*—Condition about the same. Profuse perspiration continues at intervals. Dr. Fuller of Sweetsburgh joined me in the case. Ordered ℥iss whiskey per diem.

Nov. 5*th.*—Mind wandered a little during the night. Sweating not so profuse. Little or no sleep. Pulse, 128; temperature, 101.6°F. Fits of spasm recur at slightly longer intervals. Rigidity continues. Opisthotonos distinctly marked. Mind quite clear this morning. Takes nourishment and stimulants, and experiences no difficulty in swallowing. 7 *p.m.*—Condition much the same. During the afternoon he had a severe fit of dyspnœa, which, from his father's account, appeared to have been brought on by the act of swallowing. It was so severe, and contined for

such a length of time, that his father thought he was dying. Ordered Potassii Bromid. ℥iiss ; Chloral Hydr. grs. lxxx ; Syr. Aurantii, ℥ss ; Aqua ad ℥ii. A teaspoonful every three hours.

Nov. 6th.—Slept quietly from 12 to 2 A.M. and from 5 to 7 A.M. It was noticed that his jaws relaxed during sleep, but all the otber affected muscles remained rigid. Slightly delirious while awake. There is at present an appreciable relaxation in the rigidity of all the muscles, especially those of the back and neck. Can bend his head forward slightly. Temperature, 101° ; pulse, 140. Muscular spasms recur at longer intervals than yesterday. Does not complain so severely of the pain. Skin slightly moist. Mind clear. Increased whiskey to ℥iii per diem.

Nov. 7th.—Had a better night, sleeping quietly from one to three hours at a time. Muscles generally relaxing. Temperature, 101.5° ; pulse, 126. Ordered to alternate the chloral mixture with Potassii Bromid, grs. xv every three hours. Continues to take nourishment and stimulants well. 7 *p.m.*—Patient was sleeping when I called, and while asleep I could flex all the joints easily, but on awakening, they immediately became rigid. Number of spasms much reduced during the day. Opisthotonos almost entirely disappeared.

Nov. 8th.—Found him partially sitting up, and able to partly flex the legs voluntarily. The feet are still extended to their utmost limit. The back touches the bed through its whole extent.

Nov. 9th.—No cramps during the night. A moderate amount of sleep. Sits up easily, and can flex the legs voluntarily. Temperature, 102.4° ; pulse, 140. Ordered Potassii Bromid. ℥iii ; Chloral Hyd. ℥i ; Tr. Digitalis, ℥i ; Aq. ad. ℥ii. A teaspoonful 4 q.h

Nov. 10th.—General improvement. Pulse continues at 140. Whiskey reduced to ℥iss.

Nov. 11th.—Power over muscles gradually returning ; only noticeable remains of rigidity in the feet, which are still extended, and in the jaws. Omitted the Chloral and added Tr. Cinchonæ in ℥ss doses to the above.

Nov. 15th.—All tetanic symptoms have disappeared. Sleeps well ; takes food well. Temperature, 99.5° ; pulse, 130. Can

walk from the chair to the bed with a little assistance. A slight diarrhœa developed yesterday. Ordered Pulvis Ipecac co. gr. ii every six hours.

Nov. 20th.— Continues to improve. Tongue clear; pulse, 120; temperature, 99°. Occasional diarrhœa, but easily kept in check. Is taking Ferri et Ammoniæ Cit. and Tinct. Cinchonæ.

Dec. 1st.—Ordered ½ gr. Quiniæ Sulph. three times daily.

Dec. 7th.—Is playing about the house.

REMARKS ON REST AND TRACHEOTOMY.

By Prof. LOUIS ELSBERG, of New York.

[This interesting communication contains the substance of Dr. Elsberg's remarks at the meeting of the Canada Medical Association, upon the paper of Dr. Major, published in our last Number.—Ed.]

I hold that it is the duty of everyone who successfully devotes himself to a special branch of medicine to add from time to time the conclusions arrived at by himself and his fellow-specialists to the general stock of information, so that the results of special knowledge and skill may become, as far as possible, the *common property of the medical profession.* It is this duty which Dr. Major has taken upon himself to perform this evening, and he has performed it very ably. The subject is one perfectly well understood among throat specialists, but one seemingly very little known or acted upon by general practitioners. Dr. Major has given some original illustrations, and has added the results of his own observations as to glandular enlargements in cancer and the use of gold canulæ.

I personally, after reading Hilton's lectures on Rest, called the attention of the profession nearly twenty years ago to the fact that the prescription of rest for inflamed or diseased parts is as applicable to the throat as to any other portion of the body. As Dr. Major has said, the judicious practitioner prescribes rest for inflamed joints, in peritonitis, cerebritis, etc.; and one of the first points that struck me was the harm sometimes done in acute affections by the time-honored method of gargling. I suppose the very name "gargling" is connected with the gurgling sound and motion with which it is accompanied; but, as this movement

irritates the parts, I have long taught patients and medical students that when I prescribe gargling I never mean "gurgling," but throat-baking. Indeed, gentlemen, if Dr. Major has succeeded by his paper in thoroughly impressing the truth upon you about gargling, if he had done nothing more, he deserves your thanks and the thanks of your patients, for by avoiding the gargling movements while holding medicated liquids in his throat in proper positions, the patient may gradually learn to bring these liquids into contact with parts of the throat that cannot at all be touched by ordinary gargling,—and thus you may do more good and avoid all harm!

As to laryngeal rest, you know the larynx is a framework of cartilages, covered by perichondrium, united by ligaments, moved by muscles, supplied with blood-vessels, lymphatics and nerves, and lined by a peculiar elastic membrane and a mucous membrane continuous with that of the throat above and the windpipe below. Although, in by far the great majority of all cases of laryngeal disease, it is the mucous membrane that is affected, either primarily or secondarily, yet each of these constituent structures may be involved, and in each instance, rest may become an important—if not the most important—part of successful treatment. Dr. Major has related some interesting cases, and my own experience agrees with his. Under the influence of rest, inflammatory conditions subside and œdema diminishes; nervous and nervo-muscular affections, phthisical, syphilitic and malignant ulcerative diseases, and even morbid growths, may be wonderfully aided if rest enters as a factor in their treatment. The larynx is of necessity moved, in its entirety or in parts, in the production of voice, in breathing, and in swallowing; and if you desire to follow me a little further, I shall take pleasure in speaking to you, in a sort of reviewing way, of each of these three functions in connection with giving rest to the larynx.

The production of voice is voluntary, not counting exceptional involuntary vocal sounds; and by an exertion of will it can be stopped for a shorter or longer period. To stop it absolutely for any length of time is a matter of much more real difficulty than any person would *à priori* imagine, and in this connection I beg,

in all seriousness, to contradict a widespread slander upon the female sex. You know, gentlemen, the proverb says that a woman cannot hold her tongue, but the truth is, and I have tested it very often, a woman, *if she really wants to*, can hold her tongue, both literally and metaphorically, a great deal better than a man. I have had patients whose laryngeal disease could only be cured, and really was cured, by complete vocal rest, by absolute silence lasting for from one or two weeks to two months, in a few cases to even more than three months, either by this rest alone or by rest conjoined with other treatment. Such silence, avoiding the saying of even yes or no, avoiding even an audible smile or sigh, requires tremendous and constant exertion of will power, which not very many women, but far fewer men, are equal to.

What Dr. Major has said about whispering is positively true, although contrary to the general belief of patients and of general practitioners. Whispering, especially when emphatic, involves a greater strain upon vocal organs than easy, unexcited, ordinary phonation. In all cases, therefore, in which you require comparative rest of the voice, you must caution the patient not only against shouting, screaming, singing, and all loud talking, as is generally done, but also against undue whispering.

The second function in which the parts of the larynx are moved, that of breathing, although to some extent subject to the will, *i.e.*, as to its immediate performance, its frequency and relative duration, is performed involuntarily and is necessary for the continuance of life. By securing easy, physically and emotionally unexcited, quiet, unforced respiration, and regulating the temperature and character of the air that is breathed in—making it more soothing and unirritating than it otherwise would be—we can bring about comparative laryngeal rest during breathing, and by the surgical operation of tracheotomy we have it in our power to exclude the larynx from essential participation in the respiratory act. Is it even justifiable and advisable to perform tracheotomy for the purpose solely of giving phonatory and respiratory rest to the larynx? This question presented itself to me in February, 1873. So far as I knew it had never before been decided; probably, it had never before

been asked. I had long been treating a patient, Mrs. B., who had lost her singing voice, upon which her livelihood depended. She was divorced from a man who had given her syphilis some years before, had passed very thoroughly through anti-syphilitic treatment, and was now free from any manifestations unless her present laryngeal disease was such. She had certainly overstrained her voice, and for six months I had been unremitting in my care of it. She had deep fissures in the posterior commissure and a strip of red and swollen mucous membrane nearly a line in width joining the lateral attachment of the vocal bands, *i.e.*, along the external boundary of the ventricles. She complained of constant terrible aching in her larynx, but respiration and swallowing were uninterfered with. There had been inflammation involving the whole lining membrane of the larynx and for some time aphonia. I had relieved her considerably, but in spite of painstaking treatment, general and local, with absolute vocal rest for over seven whole weeks, I could make no further progress with the condition described. She was very much interested in the case of Mrs. D., whom she had brought to me as a patient, who sang in the same choir and who had passed through an experience similar to her own. In Mrs. D.'s case there was unmistakeable syphilitic ulceration and swelling, with increasing dyspnœa which had required on the 10th of December, 1872, tracheotomy to prevent suffocation, and from that date on Mrs. D.'s case progressed so favorably that by the middle of February the canula had been removed and two weeks later she again sang in the choir and gave private singing lessons. This was not the first case in which I had seen wonderful results follow tracheotomy and in which I ascribed the success of other treatment as being mainly due to the rest of function given the larynx by the operation. I had observed and recorded unexpected cures after tracheotomy in several cases in which the operation had been forced upon me by the necessity of relieving the patient from extremely painful and difficult breathing. In the year 1862 I had such a case in an unquestionably phthisical patient, and during the intervening ten years I had seen a number of others. Now, Mrs. B. hav-

ing become acquainted with my view as to the possible good effects of rest to the larynx, insisted upon my operating in her case. She was desperate; life had become unbearable to her with her throat as it was. I debated the question of the operation anxiously and conscientiously with myself and a medical friend, decided it deliberately and performed tracheotomy in February, 1873. She began to improve immediately, and in less than two months' time the interior of her larnyx looked almost healthy; in June the canula was permanently removed and ever since the autumn of the same year she has been giving singing lessons and has sung in church and in private and public concerts.

This was an extreme case but an uncomplicated one. Its success, together with the success that had attended numerous cases since—cases, however, in which some degree of stenosis indicated the operation—proves unmistakeably the good effect of the complete rest of the larynx which tracheotomy affords. The numbers of more or less successful tracheotomies in cases alone of phthisical ulceration of the larnyx, which I have either myself performed or counselled others to perform, must by this time amount to perhaps thirty. Yet, I by no means share the opinions of those surgeons who regard trachestomy as a simple or harmless operation; but I consider the value of the rest which it secures so great in appropriate cases, even in incurable cases, that this consideration goes far with me towards overbalancing its difficulties, dangers and possible ill after-effects whenever indicated by laryngeal stenosis. You, of course, understood that after tracheotomy *phonatory rest* is conjoined with respiratory rest of the larynx; but the movements which the larynx undergoes during the third function in which it takes part, viz., deglutition, are not done away with by performing tracheotomy. Comparative deglutitory rest may be secured by regulating as much as possible *the act* of swallowing, and the pressure which boluses exert upon the posterior wall of the larynx may be lessened by using mincing machines, soft food in suitable quantity and at stated times, etc. Acting on this principle of securing rest, of avoiding to irritate but on the contrary of soothing the

parts, I have been enabled to accomplish surprising results as to nourishing the patient and prolonging life in some cases of post-laryngeal and œsophageal cancer. In phthisical and other conditions of irritation of the structures over which food must pass I recommend the same measures.

Finally, protective, sedative and anaesthetic medication, local and general, frequently owes some of its good effects to the rest which it affords the part. This fact has very properly been alluded to by Dr. Major.

We have then at our command, as the means of giving rest to the larynx, medication, tracheotomy and regulation of the three functions of phonation, respiration and deglutition. The specific application of these means to an individual case of disease must, of course, be left to the judgment, the skill and the medical tact of the physician who takes the responsibility of treating the patient. Like all other therapeutic measures, when improperly applied as to time and circumstance, some of these means are fraught with danger; but, *physiological rest is likely in any case to do more good than harm*, and Dr. Major certainly deserves your thanks for his presentation of the subject. As to myself I must apologize for the lengthiness of my remarks and to express reiterated thanks for the attention with which you have favored me.

Reviews and Notices of Books.

The International Encyclopædia of Surgery: A Systematic Treatise on the Theory and Practice of Surgery.—By Authors of various Nations. Edited by JOHN ASHURST, Jr., M.D., Professor of Clinical Surgery in the University of Pennsylvania. Illustrated with chromo lithographs and woodcuts. In six volumes. Vol. I. New York: Wm. Wood & Co.

Ten years ago, when Holmes announced to the profession that he had completed the fourth volume of his System of Surgery, it was generally thought that this, with an occasional revision, would answer the requirements of the profession for at least a quarter of a century. And doubtless it would, but our American

neighbors, who travel faster in every way than the rest of the world, and who look upon decades as other nations do centuries, have long ago classed it among the literature of another age, and now yearn for something new. Agnew's Surgery, only very recently issued, and the work at present under review, are outcomes of this insatiable thirst for novelty. But give the surgical literature of America its just due, it deserves a high place in the world, and we feel convinced that the experiment now being tried by Dr. Ashurst will be productive of the best results, and will be only another illustration of what can be done by American skill and enterprise.

The first volume opens with an article on the "Pathology of Inflammation," and as a guarantee of its excellence, we have simply to mention that the writer is Dr. Stricker of Vienna. The latter takes this opportunity to cross lances with Cohnheim, whose views he disposes of in the following rather summary fashion:— "The migration theory has proved to be fruitless. It has made no progress since 1867, and in regard to the doctrine of inflammation, it cannot make any progress, for it denies the active processes. But the doctrine of tissue metamorphosis has made constant advances, and every new step which I have taken in the course of the last decade has proved to be an argument against the migration theory." Thus the article is doubtless tinged with a strong partisan color, but it is nevertheless of great value, coming, as it does, from the pen of one of the most eminent pathologists of the day.

Dr. Wm. H. Van Buren of New York contributes an article on "Inflammation," and considering that the subject is not quite in his line, it is a remarkably able production. We must confess to some disappointment in perusing the next article, by Dr. Delafield, on "Pyæmia and Allied Conditions." There is here no attempt made to differentiate the septic fevers, and the question of treatment is dismissed very curtly. The article, however, is richly adorned by two colored lithographic plates, illustrating the pathological appearances of metastatic abscesses. The subject of Erysipelas has fallen into good hands, namely, those of Dr. Alfred Stillé. Dr. Bultin contributes a well written paper

on "Scrofula and Tubercle," and takes the opportunity of airing his modern pathology. "Anæsthetics and Anæsthesia" are ably discussed by Dr. Henry M. Lyman, the historical portion of the subject being especially very full and interesting. This volume closes with an article on "Amputations," by the Editor, Dr. Ashurst. This, while exceedingly interesting and valuable, is not as complete, especially on the subject of treatment, as we might have expected. Dr. Ashurst is evidently very conservative in his method of treating wounds, as, for example, he still seems to prefer wire sutures, and dresses his stumps after the old-fashioned style, with adhesive straps, &c.

The illustrations are, on the whole, fair, and the type is large and handsome. The book itself is rather ponderous and unwieldy, but this is a minor consideration, and tends only to add to the dignity of this splendid work.

Diseases of the Rectum and Anus.—By Charles B. Kelsey, M.D., Surgeon to St. Paul's Infirmary for Diseases of the Rectum, &c. New York: Wm. Wood & Co. 1882.

This is the August number of Wood's Library, and constitutes a very valuable addition to the series. So far as we can see there is no attempt made on the part of the author to produce anything very original in the pathology or treatment of rectal diseases, but he has certainly succeeded in giving an admirable compilation of the recommendations of others. With regard to the treatment of hemorrhoids, we must confess to no little disappointment that the author should prefer the old-fashioned ligature to the clamp and cautery. Certainly he can have had no experience with the latter, or he would have given it a larger place in his book. We have tried both, but have long ago given our verdict in favor of the clamp and cautery. It is an operation at the same time easy of performance, thorough, safe, and yielding permanent good results.

The author's remarks on fistula are, to our way of thinking, clear and logical. He believes, with many others, that the chief cause of ischio-rectal abscess in phthisis is a purely mechanical one, depending upon loss of fat in the ischio-rectal fossa, and a

consequent removal of support from the hemorrhoidal veins, which, during the cough and concussion, become congested, and eventually abscess results. Dr. Kelsey is very positive in his remarks regarding the advisability of operating in cases of fistula complicating phthisis. He says: "I have yet to meet the first case, which, under suitable and careful general and local treatment, refused to heal after the operation." Further on, he cautions against operating either in very advanced or rapidly advancing lung trouble. A portion of the concluding chapter of the book is devoted to the important subject of rectal alimentation. Altogether, this work has much to commend it, and for the purposes of the general practitioner we know of none more suitable.

On Slight Ailments, their Nature and Treatment.—By Lionel S. Beale, M.D., F.R.S., F.R.C.P., Professor of the Principles and Practice of Medicine in King's College, London, and Physician to King's College Hospital. Second edition, enlarged and illustrated. Philadelphia: P. Blakiston, Son & Co. Montreal: Dawson Bros.

Prof. Lionel Beale is in the first rank of medical philosophers, and his writings are always highly original. They are instructive and couched in language extremely attractive and entertaining. The slight ailments are common to all,—all persons suffer from them more or less. But, because they are frequently not associated with any organic disease, and do not present any serious aspect, they are only too apt to be neglected or made light of, to the dissatisfaction of the sufferer and the discomfiture of his medical attendant. These lesser ills are none the less real, from their minor degree of intensity, and, taken together, make up a large sum of actual distress. As a matter of fact, also, many of these are quite amenable to treatment, provided only sufficient care and attention be given them. Indigestion, Constipation, Diarrhœa, Worms, Vertigo, Biliousness, Neuralgia, Rheumatism, &c., are a few amongst the many common ailments dealt with. The concluding chapters upon the feverish and inflammatory state, and on the common forms of slight inflamma-

tion, are particularly interesting, and contain much of the writer's special views on this subject. The book is replete with points which readily escape observation, but which will often find their practical application when one's attention has been directed to them. Every physician, especially every young physician, should have a copy of "Slight Ailments,"—and read it.

The Sympathetic Diseases of the Eye.—By Ludwig Meuthner, M.D., Royal Professor in the University of Vienna. Translated from the German by Warren Webster, M.D., and James A. Spalding, M.D. New York: Wm. Wood & Co.

"This comprehensive monograph, on the Sympathetic Diseases of the Eye, is the first of a series intended to embrace the whole province of Ophthalmology." It has been prepared more especially for the general practitioner, and thus avoids as much as possible the abundant terminology and the minutiæ of the special science. In order to meet the case of those not sufficiently familiar with the subject, a chapter is devoted to a consideration of the peculiarities of the anatomical structure of the eyeball and its tissues. After which are fully considered the ætiology, pathology and therapeutics of that important—very important—class of eye diseases in which a previously good eye has become the seat of functional or organic disturbances due to some serious derangement in its fellow of the opposite side. The great urgency of many of these problems renders it imperative for every one to possess a fair knowledge of the views of eminent ophthalmologists of the present day. This can be obtained in a very clear and concise fashion in the volume we are noticing, and we commend it to the favorable attention of the profession.

Questions on Human Anatomy.—By Samuel O. L. Potter, M.A., M.D., author of "An Index of Comparative Therapeutics," &c. With 63 illustrations. Philadelphia: P. Blakiston, Son & Co. Montreal: Dawson Bros.

This constitutes No. 1 of a series of handbooks on the various subjects comprised in a medical education, which are being pre-

pared under the title of Quiz-Compends. They are intended specially for the use of students preparing themselves for examination. This one seems to have been carefully prepared, and is complete in its various departments. It will no doubt form a useful aid in the manner intended.

Medical Electricity: a Practical Treatise on the applications of Electricity to Medicine and Surgery. —By ROBERTS BARTHOLOW, A.M., M.D., LL.D., Professor of Materia Medica and General Therapeutics in the Jefferson Medical College of Philadelphia, &c. 2nd edition, enlarged and improved. With 109 illustrations. Philadelphia: Henry C. Lea's Son & Co.

Less than two years ago we gave an opinion in these pages upon this work. It has evidently been well received by the profession (as it certainly deserved to be), since a second edition has been already called for. It is only necessary now to notice this fact, and to add the especial points in which improvements and additions have been made. The author says that, though the treatise has been specially prepared from the practitioner's rather than the scientific standpoint, yet, "in response to an increasing desire for scientific treatment," he has "developed more fully the modern methods of ascertaining and expressing current strength, tension, resistances, &c." He has also "entered more fully into the polar method and into the action and uses of the magnet."

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, November 17th, 1882.

R. A. KENNEDY, M.D., PRESIDENT IN THE CHAIR.

Dr. Osler exhibited the following Pathological Specimens:

Cerebral Aneurism and Hæmorrhage, from a case in the Montreal General Hospital under the care of Dr. Molson. The patient, a woman, æt. 62, was admitted in a semi-unconscious state, with complete paralysis of the right side, following a fit

she had had some three days before. As far as could be ascertained her previous health was good and her habits temperate. Death occurred on the 7th day after admission. At the autopsy was found a small saccular aneurism situated upon the left middle cerebral artery, which had ruptured and produced extensive laceration of the inner and anterior part of temporal lobe and hemorrhage into the meninges of the base. The arteries were atheromatous, and from the exceedingly thin structure of the wall of the aneurism it is probable that it originated in an atheromatous ulcer, exposing the middle and outer coats which had yielded to the pressure. There was no heart disease and no special change in the other organs. Dr. Osler remarked that this was the sixth specimen of cerebral aneurism he had exhibited to the society.

Verminous Aneurism in Horse.—The animal had been admitted to the infirmary of the Montreal Veterinary College with colic, and had died in about 36 hours. The post-mortem shewed intense engorgement, with great distension of the small intestines. The aneurism was from one of the mesenteric branches, and contained thrombi, among which were numerous examples of the palisade worm, *Sclerostomum Armatum.* The so-called colic of horses is very frequently produced by these aneurisms, portions of the thrombi become dislodged and plug the terminal branches of the mesenteric arteries and cause infarction of the portion of the bowel supplied by the plugged vessel. In reply to a question by Dr. Gurd, Dr. Osler stated he did not think these cases could be distinguished from those of ordinary colic. Indeed Prof. Bollinger of Munich held that colic in horses was in the majority of cases of embolic origin and due to these verminous aneurisms.

Cancer of Stomach, with enormous *Secondary Cancer of Liver.* This case was also under the care of Dr. Molson, who gave the following clinical history: L. P., æt. 52, healthy up to two months ago, when he began to lose flesh and get weak, with pain after eating and eructation of wind. On admission, November 3rd, 1882, was decidedly cachectic ; great prominence with evidence of a tumor occupying the whole of the

upper zone of the abdomen. Commencing on the right side and extending over towards the left in the median line, it extended two inches below the umbilicus and on the right side down as far as the ilium. Œdema of both legs and feet. Urine contained abundance of lithates, a small amount of albumen, and numereus granular and hyaline casts some days after admission. Jaundice set in gradually but this was never deep, and vomiting for the first time occurred. He died November 16th, p. m. The stomach showed a small, flattened, slightly raised cancer, situated on the lesser curvature, about 1½ inches from the pylorus; it had an excavated base, puckered and hard on the peritoneal surface, and a chain of enlarged glands extended along the lesser curve to the cardiac. The microscopic examination showed it to be a cylindrical-celled epithelioma. The liver was enormously enlarged, weighing over thirteen pounds, and presenting innumerable masses of secondary cancer scattered through its substance.

Erosion of Internal Carotid in Cavernous Sinus six weeks after a blow on the head. Fatal hæmorrhage from the nose.— The patient, æt. 21, had received a blow over the left eye. being one of the victims of the "Beauharnois" boiler explosion. There was a long wound extending the whole length of the eye-brow, but it was not thought he had received any other injury, as he recovered quickly. Some time after, however, he noticed that the sight of that eye was failing, and he consulted Dr. Buller, who diagnosed commencing atrophy of the optic nerve, due probably to extravasation in the sheath. He had had several attacks of epistaxis, but not of an alarming character. One morning, about six weeks after the accident, while washing his face, profuse hæmorrhage took place from the nostrils, and he died before assistance could be procured. At the post-mortem the orbital ridge of the frontal bone was found indented at the site of injury. The orbital plate presented an area of superficial erosion about three lines in width, extending beneath the *dura* from a point corresponding to the external wound to the body of the sphenoid. The left wing and body of

the sphenoid slightly reddened, the surface of the bone eroded, and at one spot in the latter the bone was so soft that it broke on a slight touch. The sphenoidal and ethmoidal cells were filled with coagula. On slitting up the internal carotid in the cavernous sinus, just as the vessel turns up to enter the skull, there was seen an opening on its interior part leading directly into the sphenoidal cells. There was a small spot of red softening the size of a ten cent piece in the third left temporal convolution. Though no fracture of the sphenoid was evident, yet it was believed that at the time of the accident a slight fracture must have occurred leading to ulceration and erosion of the bone and subsequent perforation of the carotid. Dr. Osler remarked that the case was unique in many respects, but Mr. Prescott Hewitt, in his lectures upon fractures at the base, mentions an instance in the practice of Mr. Scott of the London Hospital in which after an injury a pulsating tumor of the orbit occurred, and during an examination profuse hæmorrhage from the nostrils took place, which was controlled by compression of the common carotid, and subsequently cured by ligation of that vessel.

Specimen from a case of Diphtheria, showing blocking up of the glottis by false membrane and extension down the trachea into the primary bronchi. Tracheotomy had been performed, but with only temporary relief. A point of interest in this case was the caking and hardening of the exudation at a point corresponding to the orifice of the tube, which must have materially interfered with the entrance of air.

Dr Wilkins exhibited *Tubercle Baccilli* prepared by the Ehrlich-Gibbes method, with an important modification, as suggested recently by Balmar & Fraentzel. The sputum after being spread out on a thin layer on cover glass and dried and passed through the flame of a Bunsen's burner, is now placed in a solution of *fuchsin* in *aniline* water (one part of *fuchsin* to fifty parts of *aniline* water); it is kept in this for twenty-four hours, after which it is taken out and washed in distilled water and placed for about half a minute in dilute nitric acid (one of acid to three of water). After being again washed it is placed in a

concentrated solution of *methylene blue* for a few minutes. The specimen is then thoroughly dried, passed through a Bunsen flame once or twice and mounted in balsam.

Dr. Wilkins read a paper on a case of *Obliteration of Superior Vena Cava.* (The specimen was exhibited at a former meeting of the society.) The patient was admitted into the Montreal General Hospital on June 27th, complaining of great dyspnœa, which condition existed through the whole course of the disease. A year or so before coming into hospital he felt something give way on lifting a heavy weight, and has suffered more or less ever since. Shortly after admission he became cyanotic, with an œdematous condition of the head and neck. About six weeks after entrance into hospital fluid began to collect in the left pleural cavity, and subsequently also in that of the right side; he was tapped a great number of times, but only experienced transient relief—eight hundred and sixty-two ounces in the aggregate were drawn off. Patient's pulse, which previous to this never went above 104, now rose considerably, and the temperature, which hitherto had been normal, rose to 102°. Dyspnœa became very severe ; he was again aspirated, withdrawing twenty ounces of bloody fluid from the left side and forty ounces of clear fluid from the right. The patient finally died from exhaustion.

At the autopsy, the *superior cava*, *innominate*, *and internal jugular veins* were found obliterated by thrombi; the left pleura was covered with recent lymph; the azygos veins were widely dilated, and the foramen ovale was found to be permanent. Dr. Wilkins exhibited beneath the microscope a number of sections from various parts of the thrombosed vessels, the most interesting being those taken from the cardiac extremity of the superior vena cava, showing cicatricial thickening of a portion of the circumference of the vessel to the extent of two millimetres, the vessel itself being but six millimetres in diameter, and filled with organized clot. No other lesion could be discovered accounting for its occlusion. Dr. Wilkins considered these changes to have arisen from a primitive phlebitis, commencing in the adventitia causing changes in the intima, with subsequent

thrombosis, thus giving rise to secondary phlebitis of the vessels above, resulting in a thrombosed condition of these vessels also. Some of the sections showed fibroid thickening of the septa of the alveoli of the lungs, due to a passively congested condition of these organs. The cyanotic appearance was explained by the blood current being delayed until a collateral circulation was established. In accounting for the dyspnœa Dr. Wilkins stated that the blood of the left bronchial vein reached the heart through the superior vena cava, and consequently when that channel closed it would necessarily return to a great extent by way of the pulmonary veins, thus distending them and helping to cause thickening of their walls; he considered the permanency of the foramen ovale an important factor in causing the dyspnœa, and the remarkably slight relief obtained by aspirating the pleura. As soon as the blood current from above was shut off by closure of the superior cava the current from the inferior cava, meeting with no opposed current, must lift up the upper segment of the *annulus ovalis*, and get into the left auricle and so block up the blood returning from the lung.

Dr. Wilkins accounted for the larger quantity of fluid in the left side from the fact that on that side the blood from the four superior intercostals reaches the heart by the superior vena cava, while from only one on the right side. After thrombosis of the superior vena cava blood would reach the heart by enlarging the inosculation between the intercostals, and between these and the azygos veins.

Discussion on Paper.—Dr. Osler thought the only rational explanation of the affection was a phlebitis excited by inflammation in contiguous parts. He would not, however, attribute the same importance to the valvular opening between the auricle and ventricle as Dr. Wilkins had done; he had frequently seen this condition with an orifice of considerable size, and without giving rise to any symptoms.

Dr. Ross asked if it was not a fact that a small tube had been used in this case for continuous drainage and had been followed by pleurisy. He had seen a case of ascites treated in this way, after tapping had been performed in the ordinary way

without ill effect on two occasions, followed by fatal peritonitis in 48 hours. He was inclined to think this method was not altogether safe. In these cases is the inflammation the result of irritation or the inadvertent entrance of germs ?

Dr. Roddick also asked how the occurrence of inflammation in these cases could be explained. He doubted if these short tubes always reached the cavity, and spoke of the possibility of their slipping back, and by their constant irritation of the peritoneal or pleural surface setting up inflammation.

Dr. Osler also mentioned a case of abdominal dropsy drained in this way and followed by fatal peritonitis.

Dr. Ross, in reply to Dr. Osler, said that Southey recommended his trochar only in conditions of anasarca, but that others had recommended its use in draining serous cavities also.

Dr. Hingston spoke of the great risk always attending puncture of the abdomen, either with or without a tube, and cited a case where death had followed a single puncture in three or four days.

Dr. Roddick thought that in the case of ovarian dropsy, the operation of tapping should always be approached with great caution. He believed that an exploratory incision with antiseptic precautions was, as a rule, less likely to be followed by mischief in these cases. With regard to the operation of tapping in ordinary abdominal dropsy he was in the habit invariably of closing the puncture with a catgut suture and dressing it with iodoform, as he had seen at least one case in which septic peritonitis followed tapping where a leakage was allowed to go on for some hours.

Dr. Bell thought the history of the case did not show it to have commenced with a severe enough illness to have been a *phlebitis* and subsequent thrombosis at the time of the accident. Might not the cicatricial tissue which was found partially surrounding the vein, and which was probably the result of laceration of tissue and inflammatory action at the time of the severe strain described by the patient as the starting point of his illness, have acted by constricting the vessel so as to retard the

blood current and thus cause a thrombosis which was followed by phlebitis ? The history of the case seemed to show that the phlebitis was acute and recent when admitted to hospital, while he attributed his illness to an accident twelve months previous. The aspirations of the chest as shown by the report had been performed a great many times without any unpleasant consequences. The first time the *Southey tube* was used it remained *in situ* for twenty-four hours and then slipped out. After twenty-four hours it was again introduced, and in a few hours was followed by signs of pleural inflammation. He thought the continuous presence of the tube was the cause of this inflammation, and considered that it was almost, if not quite, impossible to leave a tube in any cavity for any length of time without air entering in at the sides, more especially in the pleural and peritoneal cavities where the action of the lungs and diaphragm exercised as it were a constant suction.

Dr. Wilkins, in reply to Dr. Osler, stated that he could quite understand, other conditions being all right, how a permanent foramen ovale could be unattended with interference in the usual course of circulation, but as soon as the current from above was cut off, the current from below would lift up the upper segment of the annulus ovalis. Dr. Wilkins showed the patient's heart with this projecting considerably, and said, supposing a force pump attached to inferior vena cava, before opening the walls of the heart and water pumped in, it would be impossible to prevent it passing through into left auricle, there being no counter current from above. The projecting upper segment of annulus is directly in the course of the fluid from below, and as it must exercise pressure on the lower portion before it reaches the upper it will unavoidably open the valvular orifice and allow escape into the left auricle. In reply to Dr. Bell, Dr. Wilkins said, in the absence of any tumor, the theory advanced by Dr. Bell was the one he was most inclined to favor until he examined sections of various parts of the vessel. No cicatricial growth of any kind existed outside of the walls of the vessel pressing on the vessel causing its closure; but for a short part of its course,

not quite half an inch, there was a very marked cicatricial thickening of the walls of the vessel itself; the cord-like feeling perceived at the autopsy was due to this and the firmly organized thrombus; the lesion was so very limited he did not think it could have resulted from the rupture of any vessel outside or in the vicinity of the origin of the superior vena cava. He did not see any reason why it might not have originated from rupture of some of the capillaries of the adventitia at the time of the patient's complaining of something giving way in his chest.

Resolution of Condolence.

Dr. Henry Howard, in speaking of the great loss which the medical profession in general and that of this city in particular had sustained in the death of the late Dr. David, moved the following resolution, which was seconded by Dr. Hingston and carried. Resolved: "That the Medico-Chirurgical Society of Montreal deeply regrets the death of A. H. David, M.A., M.D., Dean of the Faculty of Medicine of Bishop's College, and formerly a member of this society. Always highly esteemed and respected by his brother practitioners for his many sterling qualities and honest bearing towards them, being especially kind and considerate to the younger members of the profession, his loss will be sorely felt and his place can with difficulty be filled. That this society tenders its sincere sympathy to the members of the bereaved family, and assures them that the profession sympathizes with them in their great affliction."

Stated Meeting, December 1st, 1882.

Dr. T. G. Roddick, Vice-President, in the Chair.

PATHOLOGICAL SPECIMENS EXHIBITED.

Pericæcal Abscess.—Exhibited by Dr. George Ross. The following were the main clinical features of the case:

The first day there had been sudden acute pain in right iliac fossa, with great tenderness and high fever. Dr. Ross saw him soon after with Dr. Bell. They applied leeches freely and gave opiates. Immediate relief followed, and the temperature fell. For some days condition quite satisfactory. Then slight

fever and uneasy feelings in the belly. After the lapse of several days more, a chill and increased fever. From this time the temperature fluctuated greatly, accompanied by irregular chills. It was believed that pyæmic absorption was taking place from localized suppuration—but still the most careful exploration of the affected region failed to determine any fulness, fluctuation or other signs by which to localize the abscess. Dr. Ross had been strongly of opinion that a small abscess would be found behind the cæcum. The idea of operating with a view of finding the matter was earnestly discussed in consultation with Drs. Howard, Shepherd and Osler, but the difficulties in the way were believed to be insurmountable. The autopsy completely confirmed the diagnosis. A singular feature was the development of a very loud systolic murmur, so harsh that at first it was suspected to be of pericardial origin. No organic change was found in the heart.

Post-mortem.—A recent peritonitis existed, with a moderate amount of exudation; the mesentery was swollen, particularly in the upper part; about the cæcum the parts looked pretty natural, except at the inner margin, just below the valve, where there was considerable pigmentation. On dissecting this point a small saccular abscess the size of an egg was found situated behind the cæcum, and the termination of the ileum, it was quite on the inner side of the cæcum and did not extend to its outer border. It contained a creamy pus, and the walls were thick and dark. The cæcum itself was healthy. On slitting up the appendix the mucosa for half an inch looked healthy; the remainder of the tube was somewhat dilated, closely adherent to the sac of the abscess, and presented two perforations into the sac. The swelling of the mesentery proved to be an extensive abscess, involving a considerable portion of the membrane, particularly that attached to the jejunum; the mesenteric vessels in these parts were full of pus; the portal vein was distended with pus, the walls thickened, and when followed into the liver many of its branches were found dilated and in communication with saccular abscesses; there was no endocarditis.

Dr. Armstrong spoke of his having had two cases in his

practice similar to the one described by Dr. Ross, and with his experience, if another such case presented, he would be inclined to look for the matter, and let it out if possible. In the "Annals of Anatomy and Surgery" several cases are reported as having been operated upon, and with favorable results. He asked if any foreign body or concretion had been found in the abscess cavity indicating that any perforation of the appendix had occurred.

Dr. Osler remarked that the situation of the abscess in this case was such that it could only have been reached by a laparotomy. No foreign body or concretion was found in the sac. In any case of perforation of the appendix the situation of the resulting inflammation would depend on the course of the little tube which, as was well known, was exceedingly variable. In one case which he had examined, the appendix passed out at right angles to the cæcum and was attached to the sacrum; it had perforated and formed an abscess in that region, which had ulcerated into the bowel and produced fatal hemorrhage. The ulceration was usually due to the irritation of some foreign body, or, more often, of a small fœcal concretion, or, in some instances, the distal part of the tube gets cut off from the cæcal portion, the secretions accumulate and produce inflammation of the walls. In this case the patient had had typhoid fever and there may have been an ulcer in the appendix, which had produced the narrowing evident about an inch from the cæcum.

Dr. Osler exhibited a large aneurism of the thoracic aorta taken from a gentleman aged about 70, who had suffered for years with laryngitis and for the past two years with symptoms of intrathoracic tumor, dullness at the left base, feeble breathing in left lung and pain with cough and bloody expectoration. There was a doubt whether the case was one of aneurism or malignant disease. The whole of the thoracic aorta was dilated and from its anterior wall two aneurisms projected. The upper one, the size of a large fist, had a wide orifice and was densely laminated with old firm layers of fibrine. It projected into the left lung, which was much flattened by it and the

bronchus almost occluded. The other sac sprang from the vessel just above the diaphragm, and was about the size of a lemon. The posterior wall of the aorta was very atheromatous. The point of great interest in the case was the possibility of the large sac having existed for years, causing the laryngeal symptoms which had troubled him. In this situation aneurisms had been known to last for an unusually long time. Dr. Osler showed a plate from Ziemssen's Archiv. (1877) illustrating an aneurismal sac which had lasted from 1863 to 1876, and had at one time been diagnosed aneurism by Oppolzer and cancer of the lung by Skoda.

In reply to Dr. Henry Howard Dr. Osler stated that caries of the vertebræ almost always followed aneurisms springing from the posterior wall of the descending aorta.

Aneurism of the Arch of the Aorta. Specimen exhibited by Dr. G. Ross. The history of the case was as follows :—About one year ago was consulted by J. R. for a troublesome cough. Dr. J. Bell had already seen the patient and suspected aneurism. J. R. was a well-built, powerful looking man of 32 years of age. Had been only a short time in Canada. In England he practised gymnastics a great deal, and sometimes assisted in public at feats of strength. He still did some running, and even a few days previous to seeing Dr. Ross had been on snowshoes over the mountain. Never complained of shortness of breath, but had lately had a teasing cough which was increased by exertion. He had never had either syphilis or rheumatism. Patient had a constant, short, hacking cough with a marked goose-like character. On examination distinct evidence from the state of the circulation and from murmurs was found of aortic regurgation. Physical signs of aneurism were entirely wanting with two exceptions, slight pulsation deep in the episternal notch and very marked tugging at the trachea. A positive diagnosis of small aneurism pressing on the trachea was given. He was treated by rest in bed and potass iodide for several months. He entirely lost the cough. No new sign showed itself as to the chest. Repeated careful examination failed to discover pulsation or bruit other than those from the heart, no indication

of pressure on either bronchus. Two months ago he suffered from severe bronchorrhœa with fever and general disturbance and fits of intense suffocation; cough accompanied by the expectoration of great quantities of purulent matter. This entirely subsided in about two weeks. For several months the right radial pulse had been absent. He was so much better that he attended to his business till a few days ago. Death was caused by rupture into the trachea, and a vast flow of arterial blood from the mouth. The interest in the case lay in the recognition of the disease from the peculiar character of the cough, confirmed by the very marked impulse against the trachea in the absence of all other physical evidence. The laryngoscope aided also by excluding disease of the larynx and pressure upon the laryngeal nerves. Dr. R. would look upon this as an example of combined aortic valvular disease and aneurism induced from the constant over-exertion or strain of excessive gymnastic exercise. Dr. Mills gave the following report of the laryngoscopic examination. The laryngoscope was used with a view of determining the cause of the altered breathing and assist in locating if possible the aneurism. The position and movements of vocal cords found normal. The patient was asked to produce as much difficulty in breathing as he could. Upon doing so the position of the vocal cord remained practically unchanged. It was therefore clear that the cause of the dyspnœa was not in the larynx. Since the air seemed to enter each side of the chest equally well, pressure on the bronchi was excluded. The diagnosis therefore was tumor pressing on the trachea. Upon holding a double stethoscope close to the open mouth it was noticed that with both inspiration and expiration there was a wavy interruption of the breath current. This seemed to confirm the diagnosis. Dr. Mills thought this method of investigation might be of considerable value in doubtful cases.

At the autopsy the following condition was found. There was a small projecting tumor the size of a walnut beneath the manubrium. On slitting up aorta there was a circular orifice the size of a copper at the site of the innominate, and this

opened into a saccular aneurism of this vessel which projected downward and backward between the arch and the trachea. A small extension of it passed anteriorly and appeared beneath the manubrium. The sac was lined with fibrin at the peripheral part. The subclavian and carotid arose from the upper part of the sac, and about an inch above the bifurcation a rupture the size of a five-cent piece had taken place. The aorta was atheromatous, and the valves thickened, curled and incompetent. Heart hypertrophied, particularly the left ventricle.

Dr. George Ross then read a paper on *two unusual forms of paralysis* under his care in the Montreal General Hospital.

1.—*Case of Paralysis of the Tongue, Lips and Soft Palate. Acute Onset.*—J. M., æt. 45, was admitted into the General Hospital on 8th Nov., 1882. He has thick, indistinct utterance, and complains of dizziness and dull pain in the head. His trouble dates from July, 1881, and came on suddenly. The following are the particulars obtained from him: He has been a hotel porter for 25 years, and always enjoyed excellent health and was strong and robust, used to drink pretty freely, but for two years has entirely abstained. Had gonorrhæa many years ago, but never had syphilis. Has had two attacks of inflammatory rheumatism, but both occurred many years ago. One year ago last July, whilst driving a *bus*, he was suddenly seized with a *dizziness*, which was taken for sunstroke. Finding himself falling he dropped the reins and held on to the seat. He broke into a profuse perspiration, and felt a most uncomfortable dizzy sensation in the back of his head. He was lifted from the *bus* and carried into a drug store. He was then unconscious, and remained so for some hours. When he came to he was carried home, for he could not walk. At home he felt very weak, found he could not speak, and felt very dizzy. He remained in bed and on a chair for three weeks, during which time he spoke so badly that he could barely make his friends understand what he wanted. By this time he could walk about the house. Power of articulation gradually improved. He remained weak and unable to work for about nine months. Patient is a low-sized man, well nourished. Presents a

slightly dull expression of countenance. He speaks slowly, with hesitation and difficulty—all words are pronounced with varying degrees of thickness; there is no nasal intonation. His defective articulation resembles completely that of a man much intoxicated. When directed to protrude the tongue, he does so imperfectly and with considerable effort. It trembles violently. When first projected the tip is turned down over the lower lip, but is almost immediately retracted; still he tries hard to hold it out, and shuts his teeth upon it in order to do so. It is observed that at the same time the lips become quite tremulous, and the lower jaw assumes a quivering movement. When he tries to whistle he can only succeed in imperfectly closing the orbicularis oris muscle, short puffing expirations alone are produced, accompanied by a blubbering motion of the lips. He can masticate food well, and swallows without difficulty. On examining the soft palate it is seen to be much relaxed, the uvula hangs loosely on the root of the tongue, and handling it produces no reflex contractions of its muscles. Sensation in the lips and tongue appears good. Sense of taste unimpaired. Other special senses unaltered. He walks with perfect freedom, and grasps well with either hand. Reflexes normal. Heart normal. Pulse 62. Fundus oculi presents no change. Urine of natural quantity and appearance, and contains neither albumen nor sugar.

Nov. 13th.—Complained every day of pain in the back of the head, which he says often prevents him from sleeping.

2.—*Case of Paralysis of Right Side of Face, Tongue and Soft Palate.*—A. B., mulatto, æt. 53, was admitted into the General Hospital, Nov. 20, '82, with difficulty of speech and drawing of one side of the face. Has always been a strong and hearty man. Went to bed in his usual health on the night of the 16th inst.; about midnight awoke, and found that he could not speak; the next day managed to speak, but with great difficulty could hardly make himself understood. With very slight improvement this condition has lasted up to the present time. There was no loss of power in any of the extremities.

Status præsens.—A. B. is a man of large muscular form, ar-

teries stiff and somewhat atheromatous, arcus sensilis well marked, the right side of the face is observed to be flattened, smooth and wanting in expression. The mouth is drawn towards the left side, and the right angle is drooping. He can wrinkle the forehead equally on the two sides; closes the two eyes equally strongly; cannot whistle; in making the attempt the right side of the mouth does not move, whilst the left flaps. The tongue is protruded somewhat to the right side; with the mouth wide open he cannot raise the tip of the tongue against the roof of the mouth on the incisor teeth. In speaking the lingual and dental consonants give the most trouble, and the voice has an appreciable nasal intonation. There is no difficulty in swallowing, solids collect inside the cheeks and cannot be removed from inability to use the tongue. The closed temporal and masseter of the right side appear less firm than the corresponding muscles of the opposite side. On moving the lower jaw forwards it assumes an oblique position, the inclination being towards the paralyzed side, specially noticeable when the mouth is widely open. The uvula is club-shaped, inclined to the right, and the soft palate does not contract at all upon being touched or handled. Iodide of potassium has been administered, and the patient has markedly improved. Speech is quite intelligible, and he seems otherwise well.

Remarks.—These two cases present features in common and still are strikingly different. They both have thick speech and paralyzed lips, without disturbance in the limbs, the result of a sudden seizure; but the chief distinction between them is the fact that, in the first case, the paralysis is bilateral, and in the second it is unilateral. Both have arisen, I think, from a cerebral hæmorrhage which in either case must have been small. In the case of J. M. the lesion is situated, I infer, in the *medulla oblongata*. It is hardly possible to find any other situation where a single lesion could thus injure the function of these particular branches of both 7th nerves and both hypoglosal nerves. If this be true the case presents an unusual form of *bulbar paralysis*, the more serious accompaniments of this trouble being markedly absent, viz., difficulty in swallowing, difficulty in mas-

tication, and disorder of circulation and inspiration. Unusual such forms must be when we consider how closely the important centres for these functions are grouped together in the small medulla oblongata.

I might summarize the case thus: This man whilst in apparent health had a sudden giddiness and rapidly became apoplectic, remained so for some hours, could not walk for three weeks, was weak for several months. Coincident with the attack he lost the power of articulation, which still remains very imperfect. Has marked motor paralysis of the tongue, lips and soft palate. I should infer that he suffered from cerebral shock with apoplexy at the moment of the bleeding, then a complete paralysis of the tongue and an incomplete paraplegia. That the latter was caused only from functional interference with the motor parts, and was therefore entirely recovered from. That the centres of the hypoglosal and facial have been permanently injured, and hence persistent paralysis of these nerves remains. The second case showing paralysis of the hypoglosal and part of the facial on one side must be due to a lesion removed only a short distance from the contiguous seats of origin of the two nerves.

Dr. Proudfoot mentioned a case of an old gentleman, aged 81 years, subject to attacks of congestive apoplexy, but never followed by paralysis until June last, when, following an attack, he suffered from paralysis of the tongue and soft palate, great difficulty in swallowing and disturbance of speech; these symptoms have all since disappeared, with exception of difficulty in swallowing, which still exists to a slight extent.

Dr. Major read a paper on a case of *Cancer of the Œsophagus*. The patient, a female, æt. 47, was first seen by him on the 1st July last. She had suffered from difficulty in deglutition from childhood, not being able to swallow anything larger than a *barley-corn* without great difficulty; this continued with more or less varying exacerbations up to the age of forty (seven years ago), when it became so distressing that she consulted a physician, but no apparent cause was made out. When seen by Dr. Major in July last, she was considerably emaciated, and appeared to be the subject of some wasting disease. On making

a *laryngoscopic examination* the disease was found confined chiefly to the right side, the tissues between the right arytenoid and œsophagus being especially involved; and on this side a very red swelling appeared, about the size of a *pigeon's egg*, its surface studded with four or five yellow points from which some discharge escaped. The *posterior arytenoid space* was pressed upon to such an extent that the *right arytenoid* was rendered invisible. A guarded opinion at this time was given, the possibility of its being a *chondritis with formation of abscess* being considered. Iodide of potassium with a bitter principle was prescribed, and a weak spray of carbolic acid with bicarbonate of soda used to correct a slight offensiveness of the breath and to aid in the removal of accumulated mucus. This was followed by some temporary improvement, the patient became a little stronger, liquid nourishment was taken more freely, and her breathing was more easy. She was again seen and examined on the 2nd of September; her condition at that time was not so favorable, the difficulty in swallowing was increased, and her breathing was more embarrassed, the *bright red swelling* had developed into a dirty greyish mass, about the size of an acorn, and shewed a more clearly-defined œsophageal origin. The general debility advanced very rapidly, and each subsequent examination revealed local changes taking place. Softening occurred first on the left side and caused increased difficulty in the breathing by prolapse of a mass of broken-down tissue on to the larynx, and at this time a marked alteration in the voice was first noticed. Death occurred November 25th. At the autopsy the upper two and-a-half inches of the œsophagus were found involved in a cancerous mass, which almost completely obliterated the lumen of the tube. On microscopic examination it was found to be *epithelial in character*. All the other organs appeared normal.

Dr. Major remarked that the interesting features in this case were the great length of time that had elapsed between the first symptoms and the well recognized cancerous condition suggesting the existence of an originally fibrous stricture which had subsequently become malignant, and the absence of *in-*

durated glands and of *pain* to within a few hours of death. In reply to Dr. Ross, Dr. Major said that for seven years she had taken nothing but liquid diet, not on account of *pain*, but from tendency to regurgitation.

Dr. Proudfoot spoke of a case in his memory where ordinary fibrous stricture was diagnosed, and the patient subsequently died of malignant disease.

Dr. Ross said the case was a remarkable one, from the prolonged difficulty in swallowing, and he thought Dr. Major's explanation of *mechanical obstruction from simple fibroid stricture* was very reasonable. The next question to solve would be the probable cause of such a structure, possibly from injury during childhood. The disease also being so high up, where strictures are almost never found, without traumatic origin.

In reply to Dr. Roddick, in regard to œsophagotomy, Dr. Major said there was no means of making out or limiting the extent of the disease.

Medico-Chirurgical Society.—At the meeting on the 28th ult. there was a pleasing variation in the usual order of business. No regular paper was read, but cases in practice were in order. The members then adjourned to the Library, where refreshments had been prepared, and enjoyed a social evening. These friendly gatherings do good, and serve to promote the harmony and kindly feeling which characterize the profession of this city.

Toronto University.—The following Examiners in Medicine for 1883 have been appointed :—Physiology and Pathology, Dr. George Wilkins, Montreal. Medicine and Therapeutics, Dr. Eccles, London. Midwifery and Forensic Medicine, Dr. D. B. Fraser, Stratford. Anatomy, Dr. M. H. Aikens, Toronto. Surgery and Surgical Anatomy, Dr. Grassett, Toronto. Clinical Medicine and Surgery, Dr. O'Reilly, Toronto. Hygiene and Medical Psychology, Dr. Covernton, Toronto. Chemistry, Dr. Ellis, Toronto. Biology, H. Montgomery, M.A. We congratulate Dr. Wilkins on his appointment as Examiner in Physiology for the third time. It is a proof of the appreciation by his *Alma Mater* of his work in this department.

CANADA

Medical and Surgical Journal.

MONTREAL, JANUARY, 1883.

ANNUAL DINNER OF THE UNDERGRADUATES OF McGILL UNIVERSITY.

The annual dinner of the Undergraduates of the Faculty of Medicine of McGill University took place at the Windsor Hotel on the 18th December, about 150 being present. The chair was occupied by Mr. C. E. Cameron, on his right being Principal Dawson, C.M.G., Dr. Lavelle (Queen's College, Kingston), Mr. Alex. Manson, and Prof. Bovey; on his left were His Worship Mayor Beaudry, U. S. Consul-General Starnes, Dr. Scott, Dr. Sullivan (Kingston), Mr. C. J. Coursol, M.P., Dr. F. W. Campbell, Rev. Dr. Stevenson and Rev. Principal McVicar. The vice-chairs were occupied by Messrs. W. G. Johnson, D. J. G. Wishart and J. H. Darey. Among others present were Mr. Geo. W. Stephens, M.P.P., Mr. J. J. Curran, Q.C., M.P., Mr. Richard White, Mr. Hugh Graham, Rev. J. B. Saunders, Drs. W. Osler, Geo. Ross, Rodger, Molson, Jas. Bell, Sutherland, Henderson, T. Wesley Mills, Greaves (Barbadoes, West Indies), McEachran, Shepherd, Alex. Munro, Girdwood, Gardner, Macdonnell, Stephen, and others.

The dinner concluded, the Chairman called upon the Secretary, Mr. J. B. Loring, to read letters which had been received from those unable to be present. The following letter was received from Dr. R. P. Howard, Dean of the Medical Faculty of McGill University:

MONDAY EVENING.

J. B. Loring, Esq., Secretary Committee of Undergraduates Faculty of Medicine:

DEAR SIR,—I very much regret that a recent domestic trial will prevent me from being present this evening at the annual dinner of the Undergraduates in Medicine. Nothing less than something of the kind would have prevented me from availing myself of the opportunity of testifying to the interest I feel in the welfare and advancement of medical

students generally, and of those belonging to my own Alma Mater more especially. And as the interests of the Medical Undergraduates are very much concerned in the success of a movement recently begun, the object of which is to commemorate the memory of our late Dean in a way that would have been most congenial to his feelings, viz., in the extension and improvement of our means of teaching Medicine, I am pleased to be able to say that the as yet few friends who have been called upon in behalf of the "Campbell Memorial Fund" have responded generously, and that the Faculty hopes to have, ere long, a moderate annual income which can be devoted to the advancement of the Students' interests and of those of Medical Science and of the general public.

Wishing the Undergraduates a very pleasant evening, I remain, very sincerely yours,

R. P. Howard,
Dean of Medical Faculty, McGill University.

Letters of regret were also received from Chancellor Day, Hon. Justice Mackay, Dr. J. W. Mount, Dr. J. L. Leprohon, Dr. Fulton, Hon. L. R. Church, Dr. Alex. Johnson, Mr. James McShane, M.P.P., Hon. James Ferrier, Mr. W. H. Kerr, Q.C., Dr. Fenwick, Dr. Roddick, and others.

The toasts of "The Queen," "The Governor-General," and "The Lieutenant-Governor" were then proposed, and enthusiastically received.

The Chairman then proposed "The President of the United States," which was greeted with applause.

U. S. Consul-General Starnes responded, thanking them for the enthusiastic manner in which they had received the toast. He said they had great reason to be proud of their Alma Mater, and hoped that the undergraduates would do their share in keeping up the high standing which she at present enjoyed.

Mr. W. G. Johnson proposed the toast of "The Alma Mater" in a very humorous speech, and the toast was received with great enthusiasm.

Principal Dawson responded. In the course of his remarks he expressed the hope that their Alma Mater would always continue to do all she could for her children, and that the undergraduates would strive to assist her in maintaining the reputation of old McGill.

The Chairman then proposed "The Dean and Professors."

Dr. Scott, in responding, said he had been connected 43 years with the McGill University, and had been engaged as a teacher in the Medical Faculty for 38 years. To show the progress which the Medical Faculty of McGill had made, he said that at the organization of the Faculty there were 13 students, and this

year they had 187. He concluded by thanking them for the hearty manner in which they had received the toast.

Drs. Girdwood and Ross also responded.

Mr. J. Gardner then proposed the toast of "The Montreal General Hospital" in appropriate terms.

Dr. George Ross, senior attending physician to the General Hospital, responded, and in the course of his remarks referred to the importance of the hospitals to the medical students in training. The Montreal General Hospital, he said, was a general hospital in the fullest sense of the term, and it had always been the aim of those who had charge of its management to carry on the work of the hospital in the most efficient manner, and its doors were open to the medical students of all the Universities. He concluded by thanking them for the enthusiastic manner in which they had received the toast.

Dr. T. Wesley Mills proposed the toast of "The Sister Universities," which was duly honored.

Dr. Lavelle, of Queen's University, Kingston, in responding, thanked them for the hearty manner in which the toast had been received. McGill University, he said, was an institution honorable in every way, and well fitted in every respect to promote the interests of the Medical profession. The Dominion, he said, owed a great deal to the Medical Universities, and the Province of Quebec owed a great deal to McGill University. And to-day her graduates were taking leading positions in all the professions throughout the Dominion. In the Province of Ontario the progress that had been made in Medical education during the past fifteen years had been such as to command the respect of all who appreciated Medical Science, and he hoped that nothing would occur in the future to mar that prosperity which had attended the teaching of Medical Science in this country. He asked the Students to aid their Professors in their great work; the mantle would fall upon their shoulders in a few years, and then they would learn to appreciate the support given to them by their Students. They had now nine Medical Schools—four in Ontario, five in the Province of Quebec, and, he believed also, one in the Maritime Provinces. These Schools were all self-sustaining, but still there was always

room for improvement, and he hoped all these Schools would acquire such wealth as would enable them to carry on the important work of Medical education. He referred to the cordial feeling which appeared to exist between the Professors and Students of McGill, and he asked the Students to cultivate this intimacy with their Professors. He concluded by expressing a hope that the Undergraduates would, after they had graduated, take up their life work in such a manner as to merit the confidence of the public whom they were called upon to serve. (Loud applause.)

Dr. Sullivan, of Queen's University, also responded. He referred to the warm feeling which existed between the two Universities. He spoke of the progress which Queen's University had made of late years, and said that in an evil hour some ladies had entered in. (Loud applause.) Usually trouble came with the ladies, and some little trouble had come to them through the ladies also. The trouble was not expected, and no one could have been kinder than the male students—indeed, they thought at one time that the boys were too affectionate towards them. (Laughter.) Such was not the case, however,—it was not necessary to go into details,—but they compromised the matter as best they could, and he might say that everything was going on as before. He then referred to the honorable, upright manner in which the Medical Faculty of McGill University had acted throughout this whole matter. He was sure that they would reap their reward for their action, and it was mainly for the purpose of showing their appreciation of their services that he and his friend Dr. Lavelle had come down to this gathering. He concluded by hoping that the good feeling which had always existed between the two Universities would continue in the future. (Applause.)

Dr. F. W. Campbell, Dean of the Medical Faculty of Bishop's College, also responded in a suitable manner.

Mr. J. H. Darey proposed the toast of "The Sister Universities."

Rev. Dr. Stevenson, in responding on behalf of Divinity, said he never knew any class of students, taking them as a class, that were so kind to the poor and suffering, as the medical stu-

dents, and referred to the great work which the medical profession had to do in the world.

Mr. J. J. Curran, Q. C., responded on behalf of the Law, and in the course of an eloquent speech, expressed the hope that McGill would always maintain the high reputation which she now enjoyed.

Mr. Alex. Manson responded on behalf of the Pharmaceutical Association, "The Hand-maiden of Medicine."

The following toasts were proposed and suitably responded to: "Our Guests," "The Class of '83," "The Freshmen," "The Ladies," and "The Press."

This terminated a most successful gathering.

TEACHING OF MATERIA MEDICA.

Before the close of the half session of McGill University preceding the Christmas vacation, a petition of first and second year's students was presented to the Faculty of Medicine. It stated that the class were dissatisfied with the course of lectures delivered to them by the Professor of Materia Medica; that these were diffuse and unpractical, and compelled those preparing for examination to spend a great deal of time in acquiring unnecessary details and minutiæ, time which otherwise could be better employed; that representations had already been made on that subject in previous years, but had not been followed by material alterations; that, under the circumstances, nothing less than the resignation of the Professor would satisfy the petitioners. A similar petition was likewise addressed to the Governors of the University. During the vacation the matter was fully discusssed by the Faculty, and upon the reassembling of the classes, the Dean made a formal statement of the conclusions arrived at. He said that the Faculty could not admit the right of a class of students to dictate how any subject should be taught; but that, at the same time, Dr. Wright had agreed to introduce substantial modifications into his course with a view of rendering it more practical, and containing fewer of the undesirable minutiæ, and that he would continue his lectures as hitherto. That, owing to the present disagreement, the Faculty had thought it well to apply to the Corporation for an Associate Examiner to

take part with Dr. Wright in the Spring Examinations. That, seeing the desire of the Faculty to do every justice to the petitioners, it was hoped that the students would loyally continue their studies as hitherto. We are happy to state that, at the present time, the classes are being attended, and the work of the various departments carried on, without further interruption. We do not wish to enter here into a discussion of the merits of this particular case. We are sure that the desire of the Faculty of McGill College is to have the teaching on the important branch of Materia Medica as thorough, practical, and up to the modern standard, as that from any other chair: and, though a completely satisfactory solution of the late difficulty may not have yet been reached, still we feel satisfied that the students may now safely leave their interests in the hands of the Faculty, certain that the interests of both are really identical.

MORTUARY STATISTICS.

The practical outcome of the recent meeting at Ottawa with reference to the collection of mortuary statistics throughout the cities of the Dominion has been the publication of the following regulations governing that matter:—

An Order-in-Council, under date of December 26th, has been issued at Ottawa, cancelling the order of the 12th of July last, in connection with mortuary statistics, and authorizing the following amended regulations to apply to the collection of statistics of deaths and their causes within the limits of the following named cities or towns, and others having a population of 25,000 inhabitants or upwards, according to the census of 1880-81, that is to say:—Montreal, Toronto, Quebec, Halifax, Hamilton, Ottawa, St. John, N.B., Charlottetown, Winnipeg, Fredericton, and Victoria, B.C., to which neighboring localities may be added from time to time, or to such other cities, towns or localities, or joint cities, towns and localities, whenever, by experience, it will appear that the system is satisfactorily worked, and when sufficient means are granted by Parliament for that purpose.

In pursuance of section 31 of the Census and Statistics Act of 1879, the system involved in the following rules, regulations and forms may be put in operation in each of the above-mentioned cities by the Minister of Agriculture, whenever it is satisfactorily demonstrated to him that there is in existence for the said city a local "Board of Health" to which is attached a permanent

salaried medical officer, whether such " Board of Health " and " Sanitary Medical Officer " are appointed and paid by the corporation of the said city or by the Provincial Government, or in any other way provided by the local laws or by-laws; and on the further condition that the application of the system to any city can be withdrawn by the Minister of Agriculture for inability or negligence to carry it to such degree of accuracy as is necessary for the purpose intended.

The Minister of Agriculture may make out of the Parliamentary grant an allotment equal to one cent for every individual unit of the population, in favor of each of the cities aforesaid, in order to defray the expenses of collecting the said Mortuary Statistics, to be paid by monthly instalments or otherwise, and such allotment may be withdrawn in case of unsatisfactory working of the system.

The Minister of Agriculture may, if he deems it necessary, add to such allotment, for every one of the said cities, a lump sum not to exceed $400 in any case, to assist the local authorities in their procuring the necessary information of Mortuary Statistics, and may withdraw the granting of such lump sum.

Pursuant to section 30th of " The Census and Statistics Act of 1879," the Governor-General in Council will, whenever one or more or all of the said cities have complied with the requirements hereinbefore stated, appoint the Sanitary Medical Officer of the local Board of Health a statistical officer for the collection of Mortuary Statistics, from the local records, which appointment may be made to terminate for reason of unsatisfactory working of the system.

The salary of the statistical officer aforesaid shall consist of twenty-five per cent of all the sums allotted as aforesaid to the city for which he is appointed; which salary shall be paid to him by the Minister of Agriculture.

In case of epidemics or endemics, or in the case of contagious or infectious diseases threatening or breaking out, the Minister of Agriculture may cause special investigations to be made in any locality, by any or several of the said statistical officers, and regulate and defray out of the parliamentary grant the cost of such investigations.

The Minister of Agriculture may request the statistical officer to supplement the numerical returns by such statements and information as relate to the various medical and other questions relevant to the subject of accidents, crimes, diseases and public health as causes of deaths reported by the Mortuary Statistics as aforesaid.

Body-Snatching.—One can hardly take up a Montreal newspaper without finding some reference to recent body-snatching embroglios. The public are much excited upon the subject. In country parts burial of deceased relatives is effected upon private property where the remains can be watched, not in the graveyards—and much ill-feeling towards the entire class of medical students is naturally engendered. This is a very disagreeable state of things. Where does the responsibility for it rest? It rests with those who obstruct the operation of the Anatomy Act. If this law were enforced, the schools would all be amply supplied, and such a thing as body-snatching would be unheard of. We hope the Provincial Government will give this matter some attention, and, if possible, devise some means for the efficient carrying out of their own Anatomy Act. If they do this they will remove a crying evil, and a great public scandal.

Toronto General Hospital.—Improvements are still the order of the day in this model institution. New floors have been laid in many of the wards, and the walls calcomined. A convalescent building is in course of completion, consisting of two large wards, which will be used as day rooms. A large conservatory is attached. The Christmas decorations were even more beautiful than last year's. We do not remember to have seen even in London such elaborate and tastefully arranged hospital decorations. Having done so much for the comfort of the patients, the trustees should now think of the students. The theatre must now be very crowded, and quite incapable of comfortably seating 275 men, the number now in attendance. A reading-room and library, such as exist in many American hospitals, would be greatly appreciated by the students.

Hamilton City Hospital.—We had the pleasure of visiting this new Institution last month. It consists of two pavilions, with with a central administration building and a small detached ward for contagious diseases. Each pavilion has two large wards, pleasant day rooms, and nurses' quarters. For their length, the wards seem rather low and narrow, but the ventilation is excellent, and the general arrangements everything that could be desired. In the upper part of the central building is the lying-in

department, and rooms which can be used as private wards. When full, the hospital accommodates about 100 patients. The old building is used as a House of Providence. Dr. F. E. Woolverton is still the House Surgeon.

Private Asylum for Ontario.—Mr. Langmüir, late Inspector of Prisons and Charities, and Dr. Stephen Lett, of the Toronto Asylum, are about to establish a private asylum for the insane at Guelph. They have secured the house and property of Mr. Norman Guthrie, which is admirably adapted for the purpose. The accommodation will at first be limited to fifty, but ultimately the proprietors hope to enlarge the premises so as to receive at least one hundred patients. The well known executive abilities of Mr. Langmuir, and the professional skill of Dr. Lett, will certainly make the institution a success, and we bespeak for it the good wishes of our colleagues.

Kingston Medical School.—The troubles referred to in our last issue have been settled, and the Faculty has agreed to give the lady students a separate course of lectures. Co-education in Medicine has proved, and we believe always will be, a failure. By all means let women have every facility for studying the learned professions, but in medicine let the teaching be in separate institutions such as are now so successfully conducted in New York and London.

—The will of the late David J. Greenshields leaves $40,000 each to McGill University and the Montreal General Hospital. In the best interests of the city at large, it is to be hoped that this noble-hearted and well-directed charity towards our greatest educational and benevolent institutions will prove an example to others well worthy of imitation.

—As we go to press, the news reaches us of the death of Joshua Chamberlin, M.D., of Frelighsburg, at the advanced age of 84. Dr. Chamberlin was probably the oldest practitioner in this Province, and was much and deservedly respected. An obituary notice will appear in our next number.

—The *Canadian Journal of Medical Science* has, very wisely, we think, changed its name, and will henceforth be known as the *Canadian Practitioner*. Our ably-conducted contemporary also appears in somewhat new and improved form. We wish the *Practitioner* every success.

— The New York *Medical Record* has lengthened its pages, and somewhat altered its appearance. This move will, of course, give more reading matter; but we do not take kindly to the elongated visage of the paper, and are afraid that those who bind it will have to reserve a special shelf on which to place it, as it stands some two inches taller than the London *Lancet* and such like volumes.

Personal.

Dr. Wm. Grant, of Perth, has gone over to the Benedicts.

R. C. Moore, M.D. (McGill, '69), of Exeter Ont., is about to remove to Minneapolis, Minn.

Richmond Spencer, M.D. (McGill, '79), of Brandon, has been in town for a few weeks.

Montrose A. Pallen, M.D. (McGill, '64), has resigned the Chair of Gynæcology in the Post-Graduate New York School, and has gone to London.

We were glad to have a visit from our friend J. W. Whiteford, M.D. (McGill, '73), of Winnipeg.

F. F. D'Avignon, M.D. (McGill, '71), was in town for a few days this month. He is in practice at Leadville, Col., and gives a glowing account of the progress of the city in the past few years.

W. H. Howey, M.D. (McGill, '78), of Delhi, Ont., has been appointed one of the assistant surgeons on the Eastern Division of the C.P.R.

Richard Whiteford, M.D. (McGill, '57), has been appointed Professor of Physical Diagnosis and Diseases of the Chest in the lately organized Toledo Medical College. We congratulate Dr. Whiteford on his appointment, and the Faculty in having secured so able a coadjutor.

Wm. McEachran, M.D. (McGill, '79), V.S., has gone to Winnipeg, where he intends to commence practice as a Veterinary Surgeon. Dr. McEachran has been one of the lecturers at the Montreal Veterinary College for the past three years, and has but recently returned from Nova Scotia, where he has been Government Inspector, investigating the Pictou cattle disease. We wish the Doctor every success in his new home.

J. B. Lawford, M.D. (McGill, '79), is at present acting as one of Dr. Savage's assistants at Bethlehem Hospital, London.

He was for some time Mr. Nettleship's assistant in the Ophthalmic Department of St. Thomas' Hospital, and we are glad to see that he has been doing good work in this line. The report of this department in the St. Thomas' Hospital Reports is from his pen, and at the meeting of the Ophthalmological Society of Great Britain, on the 14th ult., he read a paper on "Central Amblyopia in Diabetes," and exhibited sections of the optic nerve from a similar case.

Medical Items.

—We understand that Mr. Dyer, of the Branch of the Medical Hall on Phillip's Square, has recently assumed the entire ownership of that well-known establishment, which he has so long and successfully managed.

—Dr. Thomas Payne died in Huron County on the 2nd inst. He was Registrar of the College of Physicians and Surgeons of Ontario from 1872 to 1880, and was succeeded by his son, Dr. R. A. Payne, the present Registrar.

—The death of Von Bischoff removes one of the last of the older anatomists and physiologists of Germany, He was best known as the author of an important work on "The Development of Mammals." He held chairs successively in Bonn, Heidelberg, Giessen, and Munich, and died in the latter place on the 5th of December, aged 76.

—Duncan McGregor, M.D. (McGill, '61), died in Winnipeg on the 3rd inst., after a short illness. For many years he practised with great success in Chatsworth, Ont., and only removed to Manitoba in the spring of last year. He was a jovial, kind-hearted man, and very popular with his patients and professional brethren. He was a native of Glengary, and studied medicine at McGill, where he graduated in 1861.

—Professor Burdon-Sanderson has been elected to the Waynflette Chair of Physiology at Oxford. This will be a serious loss to London, and particularly to University College, the scene of his labors for the past ten years, and where he has done so much to advance the teaching of Physiology. Fortunately for the school which he has left, there is a man on the spot worthy to be his successor—Mr. E. A. Schäfer, F.R.S., the Assistant Professor, one of the few men in England who has devoted himself exclusively to Physiology. A favorite pupil of Sharpey's, an able and original investigator, a trained and successful teacher, his appointment to the vacant chair will be hailed with satisfaction by all old University College men and the profession at large.

CANADA

MEDICAL & SURGICAL JOURNAL

FEBRUARY, 1883.

Original Communications.

THE TREATMENT OF WOUNDS AND TUBERCULOUS JOINTS—ACUTE DILATATION OF THE HEART.

(*From our Special Correspondent.*)

VIENNA, Dec. 15, 1882.

The great pressing question of the hour in the surgical world here, as elsewhere, appears to be the treatment of wounds. It is not whether this treatment should be conducted antiseptically or not, but rather what kind of antiseptic should be used. Here, at any rate, there is no doubt of the value of antiseptic surgery. All are agreed that the grand principles laid down by Lister are sound. The method of carrying out these principles will change, but the foundation on which they are laid will stand secure. Not until we have discovered a better antiseptic than any we have at present, shall we be in a position to say whether the spray can be dispensed with or not. There certainly is no trustworthy evidence as yet that we can dispense with it in operations where the presence or absence of *septicity* means the death or recovery of the patient.

During the last year, irrigation has been used in Billroth's and Albert's wards in place of the spray. The method of carrying it out does appear to be quite as troublesome as the spray. Carbolic acid, 1 to 30, is the strength of the solution always employed. The parts to be operated on are first thoroughly washed with a solution of the above strength, and are kept constantly irrigated up to the time of using the knife. If it is an

amputation, the flaps are thoroughly irrigated for two or three minutes before they are brought together; and even after the parts are adapted, the cavity of the stump is again washed through the drainage tubes previously introduced, care being taken to squeeze out any superfluous acid. No matter what the subsequent antiseptic that is used in the dressings, the one used in the irrigation is always carbolic acid.

Iodoform, salicylic acid, peroxide of hydrogen, and naphthalin are all in use here at present, especially the first mentioned. Each of these agents is considered by their respective users to be the most trustworthy antiseptic known. It is difficult to arrive at the truth where there is so much contradiction.

Iodoform is always used in the form of what is called *iodoform gauze*, which is made in the following manner. The ordinary gauze cloth is drawn through an alcoholic solution of resin, to which has been added half the quantity of glycerine; the iodoform is then dusted on as long as it will adhere. An ounce of iodoform is sufficient for 30 yards of the cloth. Gauze prepared in the above way is used in nearly all operation cases, but especially in those about the mouth and throat. In these cases particularly it is considered to have a great advantage over carbolic and all other forms of antiseptic gauze. Billroth considers that in these cases especially it is the direct means of saving many lives. It is a well known fact that after operations on the mouth, death often follows from pneumonia and general septicæmia. The former complication is especially dreaded on account of its great fatality. This form of pneumonia runs its short and lethal course in a very insidious manner, and if the patient is not carefully examined, it may escape the surgeon's notice altogether. There is no doubt whatever about the high antiseptic qualities of iodoform. The following case, which was a severe test, is a proof of this: A man, aged 40, received on the 29th of October a severe compound and comminuted fracture of both bones of the right leg. The soft parts were extensively lacerated. On his admission into hospital a few hours afterwards, several pieces of bone, which were loose, were removed, and the wounded surfaces thoroughly irrigated with a 1 to 30 solution of carbolic

acid. All the cavities were then packed with iodoform gauze, and over this were placed several layers of Brun's cotton wool, the whole being secured by means of an ordinary gauze bandage. The whole limb was then securely bound in an iron splint by means of an organdin bandage. This dressing was left undisturbed for five days on account of the patient being free from both pain and fever. When changed at the end of the fifth day, the discharge, which had not been very copious, had no more than soaked through the layers of iodoform gauze. The discharge was sweet. There was no sign of an inflammatory disturbance in the wound or neighboring parts. A similar dressing was reapplied and left on for fourteen days. Again the wound was found aseptic. The third dressing was removed on the 29th day, with the same result. On the 40th day, the wound was superficial and aseptic.

This single case proves a great deal; it shows conclusively that iodoform, even in a very small quantity, is sufficient to keep a wound, which has been rendered aseptic, in the same condition. Billroth goes further than this, for he says that there is no antiseptic, including carbolic acid, that is so trustworthy in making a foul wound sweet. The reason that carbolic acid is used is owing, he says, more to its convenience and cheapness than to any superior virtues.

Great stress is laid on the so-called anti-tuberculous properties of iodoform. This is especially insisted on by Mosetig-Morrhof. He considers that it has peculiar powers in destroying the tuberculous granules and setting up in their place healthy granulations. In looking over the literature of the treatment of tuberculous joints by scraping and iodoform, it will often be found that the history of the case terminates with the following expression: "the patient left the hospital cured, with the exception of a small fistula." Months afterwards these patients return, saying that "their joint is much worse," and in many of these cases amputation is necessary in order to save life. In young subjects, however, it will be found that a thorough scraping away of the diseased articular surfaces and packing the cavity with iodoform gauze will lead to a fairly useful joint. Billroth has in his wards

at present a case of tuberculosis of the right elbow joint in a girl aged 15, which he treated in this manner six weeks ago, and which promises to lead to a very useful joint. It is extremely doubtful whether the iodoform does more in these cases than simply keep the wound aseptic. If the tuberculous infiltration is completely removed by the scraper, then, and then only, is it probable that we will have no recurrence of the disease. This view is further strengthened by the fact that the local treatment of tuberculous ulcers on the larynx by iodoform is valueless, at least as far as curing the disease is concerned.

When a case of tuberculosis of a joint is seen early, that is, before the articular surfaces become infiltrated, the success following the above treatment is very gratifying. Tubercle is nearly always deposited a short distance from the articular extremity of a long bone. This is particularly the case in the knee, ankle and elbow joints. To-day, I saw a section of an amputated leg where there was disorganization of the ankle to such an extent as demanded the removal of the limb. The starting-point of the disease—the caseous nodule—was plainly to be seen in the lower part of the fibula, about three-quarters of an inch from its articular extremity. Here the primary disease could have been easily removed without opening the joint if the patient had been seen earlier.

Since the above was written, a very animated discussion was held in the Medical Society of this place on the treatment of tuberculous ulcers of the larynx by iodoform. Prof. Schnitzler, who opened the discussion, said that he had seen a number of cases cured, when treated by blowing iodoform over the surface of the ulcer daily. Prof. Schrötter, who had seen "many thousand cases of tuberculous ulceration of the larynx," replied that he never once noticed any favorable influence exerted by iodoform. He had seen four or five recoveries, but iodoform was not used in any of them. The Society intend appointing a commission to investigate the subject.

Peroxide of hydrogen is used by one eminent surgeon connected with the Vienna school. It is both styptic and antiseptic. I had the privilege of following the after treatment of a case of

amputation above the ankle joint, where it was the antiseptic used. During the first few days the wound was aseptic, but it afterwards became septic; this change was due to carelessness in applying the dressings, and not to any failure of the peroxide as an antiseptic. In a case of elbow excision in a boy, I saw, during the operation, its styptic properties tested, and in the subsequent dressings, its antiseptic qualities. It withstood both tests. It is a good dressing for syphilitic ulcerations. The method of employing it is simply to apply cotton wool, holding it in suspension to the wounded surface, and over this a layer of dry wool. I believe that the ophthalmic surgeons find it an excellent remedy for all forms of purulent conjunctivitis.

Acute Dilatation of the Heart.—It has only recently been recognized that during the often slow progress of organic disease of the heart, one or all of its cavities may become suddenly dilated. That this may happen even in those cases where the patient was previously unaware of any cardiac trouble, the following case shows. A woman, aged 23, was admitted into Schrötter's wards, on the 13th of November, complaining of violent palpitation of the heart. With the exception of being pale-faced, and troubled with slight palpitation on exertion, she enjoyed good health until fourteen days ago, when her heart commenced to beat with great rapidity. When examined on Nov. 14th, a pulsation visible at a distance of several feet, was noticed. It extended from the 3rd to the 6th ribs. The apex beat was half an inch to the outside of the nipple, and well marked. A distinct presystolic thrill could be plainly felt on laying the hand over the heart. The vertical dullness extended from the lower border of the 2nd rib, and the transverse from the right edge of the sternum to just outside the nipple line. Two murmurs were audible at the apex, differing greatly in acoustic properties—one presystolic, being soft and musical; the other systolic, loud and rough. In addition, there was heard in the aortic area two independent murmurs, one systolic and the other diastolic. The 2nd pulmonary sound was accentuated. Forty-eight hours after the above examination, another was made, and it was found that the cardiac dullness was less by two finger-

breadth's, both in its transverse and vertical diameters. Ten days later the heart's dullness was considered to be but slightly above the normal, and all the murmurs, with the exception of the presystolic at the apex, had disappeared. After a stay of three weeks, she left the hospital, feeling as well as she ever did.

It is to Dr. Heitler that we are mainly indebted for pointing out the nature of such a case as the above. It is very important that this condition should be before a physician's mind when examining cases of sudden heart failure, for otherwise he will be led into grave errors of diagnosis and prognosis. If acute dilatation should happen in a previously healthy heart, we have a temporary mitral insufficiency which may be readily mistaken for an acute endocarditis or an old organic lesion of the valve, or, if during the course of an acute endocarditis, an acute dilatation of the cavities sets in, the condition may be mistaken for an old disease or an exudation into the pericardial sac. The acute dilatation may be limited to the left ventricle or left auricle alone. Sometimes it commences in one cavity and spreads gradually to the remainder, its progress being in this case easily detected by daily physical examinations. It may disappear as quickly as it came on, leaving the muscular structure, however, no doubt in such a state as will readily yield again to any exciting cause. It may lead, in the first instance, and does eventually in nearly all cases, to paralysis of the heart. It is not uncommon during the progress of typhoid and pneumonia. It is seen during the course of chronic Bright's disease, not only in those cases where there are cardiac complications, but also in those where no such change can be detected. Typical examples of it are often seen in the contracted kidney, with hypertrophy and dilatation of the heart. Attendant upon and due to the acute dilatation of the heart are the following symptoms when it reaches an extreme degree: Small pulse, a weak and at times an absent second aortic sound; cyanosis, and pulsation in the jugulars if the right ventricle is the seat of the change. Enlargement of the liver, albumen in the urine, and œdema of the lower extremities, come and go with this change also.

The best way to treat this condition is by absolute rest in bed

and digitalis. In the case here reported, convallaria (*lily of the valley*) was given, but it is very doubtful whether it was useful or not. In ordinary cases of heart failure, it has proved unsuccessful.

CASE OF INTRA-UTERINE SARCOMA WITH (PROBABLY CONGENITAL) ATRESIA OF THE CERVIX.

By WILLIAM GARDNER, M.D.,

Prof. Medical Jurisprudence and Hygiene, McGill University; Attending Physician to the University Dispensary for Diseases of Women; Physician to the Out-Patient Department, Montreal General Hospital.

(*Read before the Canada Medical Association, at the meeting in Toronto, September*, 1882.)

I was called on the 24th May, 1882, by my friend and former pupil, Dr. J. Smiley, then of Rawdon, P.Q., to see a patient with the following history and symptoms: Miss G., æt 30, unmarried; had never menstruated; was a very tall, spare person, who had never been very strong, but had always enjoyed good health till April, 1881, eleven months previous to my visit. At the time mentioned she suffered from nausea and vomiting with lumbar pain. During the year following this, she had indifferent health. Appetite was defective, occasionally she vomited, and had diarrhœa alternating with constipation. In April, 1882, Dr. Smiley was consulted for dyspeptic symptoms, loss of appetite and weakness which were not relieved by treatment. On May 2nd, and following days, the doctor saw her at her lodgings. She felt very ill; had pain in the left iliac region, vomiting and constipation, with difficulty and pain in defecation and micturition. On examination he found the local conditions now to be described. At the time of my visit the temperature was 102°, pulse 112, the tongue coated, yellow and dry, she was unable to take anything but milk and beef tea. There was no pain, and but slight tenderness of the abdomen. The breasts were nil, the pubic hair present in normal quantity, slight pigmentation of the linea alba from the umbilicus to the pubes, and enlargement of the abdomen of the form and to the extent of pregnancy of 5½ months. The tumor was firm, elastic, rounded, smooth, and but slightly sensitive.

On vagnial examination the passage was found to be narrow (at Dr. Smiley's first examination the hymen was intact), short and encroached upon in all parts of its roof by the same firm, elastic, distinctly moveable body felt through the abdominal wall. A small nipple-like soft prominence with a depression on its centre felt on the vaginal roof was proved by the speculum and sound to be a rudimentary vaginal portion of the cervix with closure of the os. The diagnosis made by the physician in charge was retention of the menses from atresia of the cervix. In this diagnosis I was disposed to concur, although there was an absence of some important signs, such as periodically recurring menstrual molimen and gradually increasing abdominal enlargement. We decided to open and evacuate the uterus. The patient being etherized and a small-sized Sims' speculum introduced to the vagina, the vaginal portion was fixed with a tenaculum and a small slender knife, bent at an oblique angle on the flat introduced through the depression, cutting through about ¾ of an inch of tissue before it entered the uterine cavity. A small quantity of dark red fluid blood, mixed with flakes resembling in color and consistence little bits of broken-down brain substance, escaped. The opening was dilated first with an Ellinger dilator, and subsequently with the finger. We then found that the uterus contained not only blood, but a very much larger quantity of the brain-like substance already spoken of attached to the fundus and posterior wall. About 15 ozs. of blood escaped, and more than twice this quantity by measure of the brain-like substance was easily broken down and removed. The uterus was emptied as nearly as possible. It was much reduced in size, but it did not appear to possess much contractility. The patient speedily rallied, and when she regained consciousness, was quite cheerful. The after-treatment consisted of frequent carbolized intra-uterine injections administered by means of Chamberlain's glass tube and a fountain syringe. During the six weeks which she survived the operation, there was a constant fever, varying but never exceeding 103°F. The vaginal discharge contained blood and varying quantities of the same substance as removed at the operation. This discharge became

very fætid at the end of five days, and so continued. On the 14th day there was a tendency to chilliness, an increase of pain, and the development of a solid hard swelling in the region of the left ovary, to be felt by both the abdomen and vagina. There were occasional hemorrhages, but these were never excessive. On the 21st June temperature was 103° F., pulse 133, tongue dry, brown and cracked; the uterus large and hard, as before the operation; the uterine walls could not be made to collapse. A large quantity of new growth could be felt with the finger in the os uteri. From this time till the 11th July, the date of death, she gradually sank, suffering at times severe pain. For the notes of the progress of the case subsequent to the operation, I am indebted to Dr. Smiley, as I did not again see the patient. No autopsy could be obtained. The portions of tumor removed were examined by my friend, Dr. Osler, pathologist to the Montreal General Hospital, and by him pronounced to be a round-celled sarcoma.

Such a case as I have just related must be, if not unique, at least exceedingly rare. Atresia of the cervix uteri, it is true, is not exceedingly rare, and has been found to exist at all ages; before and after puberty; causing retention of the menses; during pregnancy, leading to dystocia, and especially after the menopause, when it is much more frequent, causing occasionally hæmatometra, pyometra, hydrometra, or physometra. A case of atresia of the cervix of the gravid uterus at full term occurred in my own practice a few years ago. In this instance the patient had already borne a child, having been delivered with forceps. The atresia must, of course, have occurred during the second pregnancy. Another similar case was discovered in a woman in labor at full term in the University Lying-in-Hospital of this city. The cause in these latter cases is usually adhesive cervical endometritis. The condition of atresia of the cervix may exist, and Mayrhofer asserts that it does so not rarely at birth, and then may be said in strict sense to be congenital from a defect, or as Müller believes, an excess of development; or it may be the result of cervical endometritis occurring during the later months of fœtal life after the for-

mation of the uterine cavity. That such an inflammation occurs in fœtal life is amply proved by the frequent existence of a copious secretion of mucus, and extensive proliferation of the epithelium of the body and cervix uteri filling up this organ, and also the vagina. I have already expressed the opinion that in the case here recorded the atresia was congenital; nothing more than an opinion can be expressed on the point. The fluid contents of the uterus had not the characters of long-retained menstrual blood, and were probably rather the result of hemorrhage from the soft rapidly-growing tumor, into the cavity of the uterus. Any information from facts as to the presence or absence of the ovaries and Fallopian tubes was not available, as no autopsy was obtained. The complete absence in the history of the case of any symptoms of periodical menstrual molimen would seem to confirm these opinions.

(914 Dorchester St., Montreal.)

A BRIEF ACCOUNT OF THE RECENT LONGUE POINTE MURDER CASE.

By T. G. RODDICK, M.D.,

Professor of Clinical Surgery, McGill University; Surgeon to Montreal General Hospital.

On the morning of the 19th January, of this year, I was called to Longue Pointe (a village about 7 miles from Montreal), to attend William Nesbitt, a young farmer, who, it was alleged, had been shot in the neck by a discharged servant. My friend Dr. Mount had also been summoned to the case, and was awaiting my arrival before making an examination. We learnt that the unfortunate fellow had been shot about three hours previous while stooping over a milk pail in his stable, the man who fired standing within three feet of him. He had sufficient strength immediately after to close with and throw the murderer, a man about his own weight, but on reaching his house, a few yards distant, fainted. He soon rallied, however, and with the assistance of his wife, harnessed a horse and drove to a neighbor's house, a distance of over two miles, and here it was that I first saw him.

We found him sitting in a chair, looking anxious, but not pale.

He stated that he had been spitting blood ever since the shooting, but by this time the saliva was barely tinged. He complained of no pain. There was slight dilatation of the left pupil. On examination, we discovered on the left side of the neck, opposite the angle of the jaw, a patch of burnt and blackened integument as large as a Mexican dollar. In the centre of this was an opening, behind the posterior border of the sterno-mastoid, which admitted, with the utmost ease, the porcelain point of Nelaton's probe. The edges were distinctly inverted. The probe passed readily in a direction slightly forwards and to the right side for a distance of about two inches, when it met with some obstructing tissue. The hemorrhage from the wound had been very trifling from the first. On examining the throat, we noticed immediately behind the uvula, in the middle line of the pharynx, an opening with blackened and everted edges, through which a probe could be passed for a short distance towards the left. Following the line of the bullet, we discovered a tender, swollen, and slightly emphysematous spot below and behind the angle of the right jaw. The patient stated that his assailant had struck him with the blade of a shovel on the right shoulder, and he thought also the right side of his face. The presence of emphysema, however, led us to believe that the bullet had penetrated the tissues about the angle of the jaw, but whether it was still present there we were unable to decide at the time, as the swelling prevented us from localizing it. To prove that the wounds in the neck and that in the pharynx were openings of *entrance* and *exit*, we injected a carbolized solution, and found that it passed readily into the mouth. We cleansed out the tragé of the bullet in this way thoroughly, and then dressed the external wound with iodoform. The patient had some difficulty in swallowing, and movement of the jaw was painful. He was ordered a gargle of carbolic acid and glycerine, with frozen milk and beef tea internally.

For the first two days the patient did remarkably well, complaining only of great stiffness in the jaw, so that the mouth could not be opened, and soreness in swallowing. The neck was stiff and had to be supported.

Jan. 22*nd.*—Great difficulty in swallowing; jaws tightly closed; great soreness about right cheek; what is thought to be the ball can be felt near anterior border of masseter muscle; profuse salivation; slight paralysis of seventh nerve on right side; is for the first time depressed and anxious about himself; wound looks well and is beginning to suppurate; is drained thoroughly by rubber tubing; pulse, 90; temperature, 100°.

Jan. 23*rd.*—Pulse, 100; temperature, 101½°; has had a bad night, being constantly disturbed by the saliva collecting in his mouth; jaws more open than yesterday, but when he attempts to swallow they are noticed to close suddenly, causing the teeth to grind together; the ball can now be felt with the finger in the mouth, lying beneath the mucous membrane, but an attempt to remove it causes such pain and spasm that it is not thought advisable to persevere; paralysis of the seventh nerve more marked, and there is also slight ptosis of right eyelid; he begs for something to clear his throat, and has a constant dread of suffocation; ordered a draught of bromide and chloral.

Jan. 24*th.*—Condition less favorable; every attempt to swallow is followed by spasm of the muscles of the pharynx, jaw, and face generally, of a tetanic character; taking food by the mouth has become absolutely impossible, so that injections per rectum of beef juice, brandy and milk, egg, &c., are ordered; the wound looks fairly well, discharging pus of a thick mucoid character. Dr. Fenwick saw the patient with me to-day and had an opportunity of witnessing one of the spasmodic attacks, brought on by an attempt to inject the canal. On this occasion we noticed that the nares were also closed, so that no air could enter the lungs, and before the relaxation took place the face had become livid and death from asphyxia seemed to impend. The patient articulates in a peculiar halting fashion, pronouncing each word with fair distinctness, but with a long interval between his words. He explains that this is done to prevent a more frequent occurrence of the spasms. The sterno-mastoid muscles are now in a condition of tonic spasm, this becoming more marked as the convulsion approaches. There has hitherto been no opisthotonos, although towards the conclu-

sion of the seizure the body is thrown forcibly back, with very slight arching, and the limbs become rigid. An attempt to protrude the tongue on one occasion brought on a convulsion. The jaws have, however, been firmly set for some hours. A solution of bromide of potash and chloral is ordered to be given by enema.

The patient died on the following night from exhaustion consequent on the convulsions.

The *autopsy*, at which Drs. Mount, Mousseau and Bell kindly assisted, showed the viscera to be healthy in every respect, the membranes of the brain being only slightly congested.

We found it impossible to make a satisfactory dissection of the parts traversed by the bullet on account of their blackened and sloughy condition, but judging by comparison with the other side we thought that the glosso-pharyngeal nerve must have been wounded just about where it lies on the stylo-pharyngeus muscle. The pharyngeal plexus, likewise, could hardly have escaped. Following the line of the bullet we discovered a piece of the paper wad embedded in the internal pterygoid muscle of the right side, which was also blackened with powder. Here the bullet evidently struck the ramus of the jaw, although there was nothing on the bone to indicate the point of impact. Considering the direction of the wound, however, it must have struck the bone at an angle considerably greater than a right angle, and hence we found it exactly where it had been located, namely, near the anterior border of the masseter muscle. It was a bullet of large size, flattened at one part, and corresponded with those found near the place of assault. Another medico-legal point of some interest, is that the wad, before mentioned, was identical with the paper that surrounded the ammunition.

Thus the symptoms during life, and post mortem appearances, it will be noticed, are easily reconciled. Injury to the glosso-pharyngeal nerve and pharyngeal plexus would account for the remarkable reflex phenomena, the branches of communication being so widely extended. The salivation, which proved so troublesome a symptom, was in all probability due to the near presence of the bullet to Steno's duct.

BI-MONTHLY RETROSPECT OF OBSTETRICS AND GYNÆCOLOGY.

Prepared by WM. GARDNER, M.D.,

Prof. Medical Jurisprudence and Hygiene, McGill University; Attending Physician to the University Dispensary for Diseases of Women; Physician to the Out-Patient Department, Montreal General Hospital.

Corrosive Sublimate Solution in Antiseptic Midwifery Practice.—In a short paper in the Nov. 1882, number of the *Annales de Gynécologie*, Dr. Ad. Ollivier, *interne* at the Maternité in Paris, speaks of the results of recent experience with corrosive sublimate solutions. It will be remembered that at the London meeting of the International Medical Congress, M. Tarnier described the method by this antiseptic and its advantages over other antiseptics. He then related the results of experiments comparing corrosive sublimate with other antiseptics. It was found to be much more powerful in preventing the development of bacteria than either carbolic acid or boric acid. The solution used at the Maternité is one to a thousand (Liqueur de Van Swieten.) Every person, midwife, interne, or student entering the lying-in room is required immediately to wash the hands in this solution. Salivation has never been noticed. If possible, each patient on entering has a bath, but in any case the whole genital region is most carefully washed with a one to two thousand watery solution, next a tepid solution of the same strength is injected to the vagina, then the vulva is covered with a compress soaked in the same solution. During labour, the vaginal injections are repeated every three hours. After delivery a final injection and toilette of the genitals is performed. The patient is then removed to another ward. If the course of the puerperium is favorable the genitals are bathed three or four times a day, and the vulva kept covered with compresses soaked in a one to eighty carbolic solution. But in instrumental labours, or in cases where there is reason to believe that some remains of membranes have been retained in utero, or if there are lacerations, or especially if the lochia be fœtid, then vaginal injections of the one to two thousand solution, repeated five or six times a day, are given, and compresses soaked in the same

solution kept constantly applied to the vulva. The experience of the method has shown that when there is fœtor of the lochia one or two days suffice to remove it, fever rapidly subsides and involution proceeds more rapidly than usual. The gums were examined carefully every day, but no evidences of ptyalism were observed. A mercurial eruption on the genitals and inner aspects of the thighs was observed in three cases; on suspending the compresses and applying starch powder this soon disappeared. The same results sometimes follow the application of carbolic acid. Since the 29th of June to date 350 women have been thus treated with only one death, and in this case the autopsy revealed traces of former peritonitis which probably predisposed the patient strongly to a recurrence of the disease from which she died. This is a most exceptional shewing of the results of midwifery in hospitals.

Dr. Ribemont, a pupil of M. Tarnier, in a case of septicæmia, gave intra-uterine injections of one to a thousand solution. The woman recovered rapidly and without any symptoms of mercurial poisoning. Similar good results followed in a case of the same kind at the Maternité.

Subinvolution of the Uterus.—Dr. John Williams, assistant obstetric physician to University College, London, read a paper on this subject in the section of obstetric medicine at the last meeting in August of the British Medical Association. The condition, the author said, is very frequent and important in the diseases of women. Involution of the uterus consists of fatty degeneration of the enormously developed fibre-cells of the uterus and their absorption. This is followed by regeneration and growth of new fibres. Subinvolution has been estimated in various ways. 1st, Measuring the height of the uterus above pubis. This is open to fallacy; the uterus may sink in the pelvis. 2nd, Measurements by callipers—one arm on the os in the vagina, the other on the abdomen. 3rd, Daily transverse measurement of uterus at its widest part. This may lead to false conclusions unless the bladder is first emptied. 4th, Daily measurements of the depth of the uterus with sounds or bougies, as performed by Dr. Sinclair of Boston, U.S.

Dr. Williams sums up the causes of subinvolution as follows: General debility; multiparity at advanced ages; post-partum hemorrhage; retention of portions of placenta and membranes; lacerations of the perineum, and pelvic inflammations. Its results are hemorrhage, dysmenorrhœa, and prolapsus. The prevention consists in the removal, to as great an extent as possible, of the causes which lead to it. Some of these are irremovable; but post-partum hemorrhage, laceration of the perineum, pelvic inflammation, retention of portions of placenta and membrane, can in a great degree be prevented. Wounds of the perineum must be immediately and completely closed. There is no doubt that the cases where this is done make better recoveries than those in which it is neglected. Goodell of Philadelphia claims that too long rest in bed favours subinvolution. His plan is getting the patients out of bed daily for a short time during the first four days; after that they get up and dress. The chief advantage claimed for this method is that drainage of the uterus and vagina is secured. Dr. Williams has not practised this latter, but he claims equally good results with Dr. Goodell by an opposite course. Vaginal injections are most valuable in favouring involution. They must be commenced immediately after delivery, be hot, abundant, and contain a disinfectant—three or four pints at a temperature of 110 to 115°F. Dr. Williams concluded his paper by saying: "The prevention of subinvolution means three things—an empty uterus, a well-contracted uterus, and the absence of fever; and I know of no better means of securing the second and third objects than the use of hot disinfecting vaginal injections and closing wounds of the perineum."

In the discussion which followed, Dr. Playfair said that he believed unhealed lacerations of the cervix oftener caused subinvolution than those of the perineum. Dr. Edis of London thought that general debility during pregnancy ought to be removed, as it favoured subinvolution after delivery. Quinine and iron, and the regulation of the nutrition and secretory functions were important. This would lessen the frequency of abortions and protracted delivery. The use of the forceps when neces-

sary should be resorted to, thus lessening danger of post-partum hemorrhage, and lessening the danger of retention of portions of placenta and membranes. Septic fever and inflammation would thus be less frequent. Ergot and the systematic use of the binder favor involution by causing contraction. The avoidance of too stimulating a diet and of alcohol unless indicated is important. He commended the hot antiseptic vaginal injections. He believed that the omission to suckle the child favoured subinvolution by the absence of that stimulus to contraction of the uterus. It was a question, too, whether belladonna, so often used as plaster, lotion or ointment in these cases, to prevent mammary troubles, had not some influence in lessening contraction of the uterus and so retarding involution.—(*Brit. Med. Journal*, Sept. 2, '82.)

The Diagnosis and Treatment of Chronic Inflammation of the Ovary.—This is the title of a paper by Mr. Lawson Tait, published simultaneously in the July number of the *American Journal of Obstetrics* and the *British Medical Journal* for July 29, '82. I will only allude to the questionable propriety of simultaneous publication of an article in two widely circulated English journals. In this paper the author enunciates some rather novel, startling, and original views, entirely at variance with those previously held and accepted with reference to certain diseases and physiological functions. After referring to the impetus given to gynecology by Thomas Keith when he taught us that our traditional fear of the peritoneum was only a bugbear, and that it would serve us as well as any other part of the body, if dealt with fairly, (the mortality of Keith's and Tait's own practice being now as low as three per cent. since renouncing Listerism), the author states that the new practice has had many good results, not the least of which is that it is shedding a whole flood of light on the pathology of pelvic disease, and is even helping us to understand the physiology of the female sexual organs. "Thus my own practice, the detailed results of which will shortly appear in a special work, have convinced me that the usually accepted doctrine of the coincidence of ovulation and menstruation is wholly erroneous. The ovaries have nothing

to do with menstruation; and though I give the opinion with a qualification which may be made necessary by further experience, so far the evidence before me shows that the phenomena of menstruation depend upon the Fallopian tubes, and not in the least upon the ovaries." The other views enunciated by the author in this paper and elsewhere on this subject may be summarized as follows: Many of the bad cases of abnormal menstruation are relievable only by extirpation of the ovaries and tubes. In chronic ovarian disease the Fallopian tubes are chiefly at fault. All the cases heretofore regarded as instances of menstrual recurrent pelvic cellulitis or peritonitis are really tubal dropsy and ovarian disease. For such conditions, if the symptoms are not speedily relieved by the treatment, medicinal or other, adopted, he performs the operation of removal of the ovaries and Fallopian tubes. In perfect health the ovary is an organ of the existence of which the owner is ignorant. It is only when diseased that its existence is indicated. Then, however, it causes great discomfort. Acute inflammation of the ovaries is often fatal, and when not fatal, it is apt to lead to a state which makes life-long misery from the chronic form. Sometimes there is no acute attack, or, at all events, no history of such. Of the acute disease the origin is various,—a simple chill, a hæmatocele, a gonorrhœa, an exanthematic fever, or a labor at full term, or miscarriage. In the treatment, rest is, of course, important, but physiological rest cannot be obtained for the ovaries. They will continue to attempt to perform their function of ovulation, and every month, or oftener, the inflamed organs are temporarily congested by the occurrence of menstruation. Much may be done, however, by absolute rest in bed for the whole menstrual week and absolute abstinence from intercourse. It is very rare, however, that we can persuade patients to carry out this regimen long enough, and hospital patients will not attend to it at all; indeed they cannot. Counter irritation, by blisters or setons, is also indicated. The only drugs of the slightest use are the salts of potash and ergot. After a persistent trial of these measures, if they fail, then Mr. Tait believes that we have only one resource—the operation he now proposes, and which he claims to

have performed often enough to enable him to speak with authority. He had, at the time the paper was written, operated by removing the uterine appendages in 35 cases of chronic oöphoritis, with only one death ; but he believes that such success can follow only the surgeon who has large and constant practice in abdominal surgery. So much for the primary success. As regards the secondary results, some of Tait's cases are yet incompletely relieved, but by far the great majority of them are absolutely cured.

On the 21st of December, 1882, Dr. T. G. Thomas of New York, at the New York Academy of Medicine, read a paper entitled " A contribution to the subject of the Removal of the Uterine Appendages (Tait's operation) for Recurrent Pelvic Inflammation. In this paper, after summarizing Tait's views as recently advanced, he reported four cases of removal of the uterine appendages—Fallopian tubes, ovaries, and ovarian ligaments. In all four cases, tubal dropsy, with chronic ovaritis, existed. They were all invalids from pelvic pain more or less constant. Three of the patients recovered. They were relieved markedly at the time this paper was presented, but Dr. Thomas did not consider that sufficient time had elapsed to speak with certainty as to cure. The fourth, an unfavorable case, died. This was all the experience he had of the operation. In the paper he wished only to hold up the views of a brilliant and original investigator. After giving Tait's statistics, as summarized above, he remarked on the much better records of laparotomies in Britain than in America, and said " it behooved American operators to look at the matter in a most careful manner, and endeavor, if possible, to determine why the success had been greater there than here." Dr. Emmet, who was present, stated that he had no personal experience of the operation, but had been in England and had seen a number of cases in which it had been performed, and must say that he saw nothing else, when abroad, which interested him so much and puzzled him exceedingly. He was surprised at the success of the operation abroad, and had opportunity to see that the women upon whom it had been performed had been

very much improved by it. The improvement which had followed the operation had been something beyond conception. There seemed to be no question with reference to Tait's success, but with regard to this operation upon the broad ligament, he was not prepared to perform it at present. He wished to wait a little further for additional light upon the subject.—(*American Jour. Obstet.*, Jan. 1, '83.)

There is a mass of testimony to the value of an operation in a class of cases whose wretched condition makes them a curse to their family and a nuisance to the medical man who has them in charge. If further experience confirms the statements of these eminent surgeons, Mr. Tait will indeed have proved himself a benefactor to his race.

On Manganese in the Treatment of Amenorrhœa, by Drs. Sidney Ringer and William Murrell.—This is the title of a paper published in the *Lancet* for January 6, '83. For some time these gentlemen have been using the permanganate of potash in solution or pill in amenorrhœa. The pill form is the best, as the solution is very disagreeable. They have notes of 69 cases, chiefly hospital, but some private. The cases were such as come under the care of the general practitioner as distinguished from the gynecologist. The dose given has been from one to four grains three times a day, beginning with the smaller dose and gradually increasing. The most striking results have been obtained by the larger doses and in young women from 18 to 25, who, from accidental or trivial cause, had caught cold or got wet, and had "missed" once or twice after having been regular. In these latter cases, the administration of one or two grains of permanganate of potash in pill three or four times a day for a few days before the time of the expected period will bring on the flow almost to a certainty. The authors often found it to succeed when iron, pulsatilla, aloes, nux vomica, strychnia and nitroglycerine had failed. It even, in some cases, brought it on when arrested in advanced phthisis and in chlorosis, without, however, improving the general condition. The manganate of soda and binoxide of maganese are equally efficacious, showing that it is the manganese and not the potash, which has the desired effect.

Leucorrhœa.—Two important papers on this subject have appeared within the last few months. One is by Dr. Fordyce Barker; the other by Dr. J. B. Hunter of New York. Dr. Barker's paper was read before the last meeting of the American Gynecological Society, and is entitled "Leucorrhœa: its Constitutional Causes and Therapeutics." Dr. Barker is well known to be opposed to what he believes to be the excessive modern development of surgical gynecology. He begins by stating that the fact that leucorrhœa is not a distinct disease, but a symptom of many different and even opposite pathological conditions, had led to a neglect of its study and to a forgetfulness of the fact that it not rarely originates from constitutional causes, and that, when long-continued, it becomes itself a cause of important local and pathological changes. Sir Charles Clark, Drs Ashwell, Henry Bennet, and Tyler Smith, who wrote from twenty-five to forty years ago, considered fully the affection from this latter point of view. Very few modern writers consider it, except incidentally as a symptom of local disease. Barnes, Stoltz and Courty are exceptions. Modern methods of physical examination had been so perfected as to lead to a careful study of certain organic changes in the pelvic organs and perhaps to a corresponding neglect of certain other equally important points, and consequently associated therapeutics. During many years past the author had seen and treated many patients who had, without doubt, received the best surgical treatment from men whom all regarded as most eminent. Some had had the cervix incised, others had had it sewed up, others had the cavity of the uterus scraped out, etc., and no doubt had been improved for a time, but often the symptoms had returned after a time. These patients were often not very interesting, either as patients or cases. Leucorrhœa is the most constant of all their symptoms, and regarded by them as the cause of all their troubles; and the author believed that there was more of truth in their theory than the profession generally was disposed to admit, for in many but slight evidence of organic disease, either through change of tissue or position, could be found to explain the symptoms. In a number of these, and also in others where there was always

found some pathological condition of the pelvic organs, the symptoms disappeared after constitutional treatment, without any local applications except vaginal injections. For many years Dr. Barker was an entire disbeliever in the opinion of Tyler Smith, that leucorrhœa was in many cases a primary cause of morbid states of the os and cervix, and while now he was not at all disposed to accept the statement that this is the fact in a majority of cases, yet within the last few years he had been convinced that it was true in some. He now believed with Tyler Smith that, in a certain number of cases, long-continued leucorrhœa caused inversion of the canal of the cervix, with increased pain and distress. The author then referred to cases of leucorrhœa which resisted all appropriate local treatment, and were cured by constitutional measures. Many of the constitutional causes, such as atmospheric changes, which induce general catarrhal inflammations; plethora in some; anæmia in others; everything which induces defective nutrition and debility, as prolonged lactation; excessive fatigue from certain employments; the continued standing position for many hours; were all well understood. He thought, however, that the influence of nerve-disturbance as a cause of defective nutrition was perhaps not so generally appreciated, although most practitioners knew the fact that in some patients, strong mental emotion was sure to bring on troublesome leucorrhœa. Leucorrhœa, with its attendant symptoms, is not at all rare in young unmarried ladies, and every year he saw many cases, chiefly from among those who came to the city "to finish their education," as it is termed. The moral depression from "home sickness," and exhaustion of nerve-power, seemed to him to be the most common of the constitutional causes in these cases. The routine prescription of some preparation of iron, under these circumstances, was sure to destroy appetite and produce headache. The object of the paper was not to describe in detail any treatment, but to draw attention anew to facts well enough known, but often forgotten, referring to the constitutional origin of this symptom.—(*Am. Jour. Obst.*, Oct., 1882.)

The title of Dr. Hunter's paper is "Uterine and Vaginal Dis-

charges." It was read in June last before the recently started Practitioners' Society of New York, and appears in the New York *Medical Record*. The author does not pretend to treat of the whole subject of uterine and vaginal discharges, but only to present a few prominent features, with especial reference to certain points of treatment. Leucorrhœa is very common. Physicians are often consulted about it. It is often treated after routine methods, which may do as much harm as good. Dr. H. divides leucorrhœa into three varieties—vaginal, cervical, and uterine. Vaginal leucorrhœa is common, and often temporary in character, from taking cold, exertion, mental excitement, or anxiety. In the unmarried, it is often due to impaired health from any cause, excessive study, irregular hours, or any form of social dissipation. Such persons are pale and anæmic, have small and capricious appetites, and constipated bowels. In such cases, it would be inexcusable to direct our remedies alone against this symptom—leucorrhœa. The general health must be improved. Hot-water vaginal injections, and then a mild astringent. One drachm of carbolic acid to a gallon of water renders it more efficacious. One drachm of tannin to a pint of water makes a good injection. Oak bark injections, as a rule, are too strong. A good injection is the fluid extract of eucalyptus globulus, one drachm to a pint of water. These local remedies and careful attention to general health must first be tried, and then, if they do not succeed, or if these symptoms are associated with pain in the pelvic or lumbar region, then we must examine If a simple vaginitis exist, nitrate of silver 20 grs. to the oz., the fluid extract eucalyptus, and the tincture of iodine, are the best. Injections containing a teaspoonful of bicarbonate of soda, or boracic acid, or common salt, are most valuable.

Cervical leucorrhœa is indicated by glairy intermittent discharge from the cervix. It often requires surgical treatment, which will depend on the condition present. The various measures are glanced at in the paper.

Uterine leucorrhœa from the cavity is often intermittent. It comes "with a gush," as the patient says, and then ceases for a time. It is often purulent, mixed with blood, and greenish.

It is particularly apt to irritate the vagina and urethra; it is worse for two or three days after menstruation, and it is often offensive; sometimes accompanied with pain. The various diseases causing such discharges and the appropriate treatment for each is considered. In some cases all varieties of leucorrhœa exist in the same person at once. Dr. Hunter wishes to emphasize the idea that all the symptoms in each case must be carefully weighed. He wishes to lay stress on the danger of a routine treatment, which may be the danger of doing too much or too little. Astringent injections often do more harm than good, if indiscriminately used. In the unmarried, we can often avoid local treatment by dealing first with the general health and insisting on hygienic surroundings. But in this, as in all others, if the symptoms are such as to cause suspicion of serious disease, then we must convert our suspicions into certainty by an examination, and give our patients the utmost benefit our knowledge will afford.

Reviews and Notices of Books.

The International Encyclopædia of Surgery: A Systematic Treatise on the Theory and Practice of Surgery.—By Authors of various Nations. Edited by John Ashurst, Jr., M.D., Professor of Clinical Surgery in the University of Pennsylvania. Illustrated by chromo-lithographs and woodcuts. In six volumes. Vol. II. New York: Wm. Wood & Co.

We have perused this volume of the Encyclopœdia with a great deal of pleasure. We consider it superior in many respects to the first. It is, however, decidedly less "international," as all the articles are contributed by English and American surgeons. The chromo-lithographs are excellent, those illustrating "senile, dry, and moist gangrene," being, in our humble opinion, genuine works of art. The woodcuts are, on the whole, good, although two or three, which are intended to illustrate the article on gonorrhœa are, to say the least, amusing. In the case of one of them intended to demonstrate the application of

lint dressing, we are certain that, if taken from life, the subject would never recognize his own penis, so completely is the organ disguised. However, the article itself on the subject, written by Dr. J. W. White, of the University of Pennsylvania, is one of the ablest and most comprehensive it has ever been our pleasure to peruse, and fully makes up for any shortcomings there may be in the mere illustrations.

The first article in this volume is written by Dr. Hunter McGuire on "Contusions." In the case of "black eye" and similar blood extravasations he recommends the withdrawal of the fluid by means of the hypodermic syringe. This sounds very well theoretically, but we question the practical value of such a procedure. In our experience the less extravasated blood is tampered with the better, as in spite of the most thorough precautions, sometimes air will enter and decomposition result. Mr. Bryant contributes the article on "Wounds," and a very valuable monograph it is. Mr. Watson Cheyne has been fortunately selected to write on the "Antiseptic Method of Treating Wounds," and does his work with a conciseness and brevity which do him credit, and which might well be imitated by future contributors. Dr. Packard's article on "Poisoned Wounds" is made very interesting, and will be found useful for reference. Dr. Bill contributes a paper on "Sabre, Bayonet and Arrow Wounds." This is a remarkable production, and coming, as it does, from the pen of an army surgeon skilled in Indian warfare, is of immense value. Dr. Connor, of Cincinnati, writes on "Gunshot Wounds," and Dr. Morton, of Philadelphia, on the "Effects of Heat." We notice with much pleasure that our old and esteemed friend, Dr. Grant, of Ottawa, is the contributor of the next article on the "Effects of Cold." The paper is necessarily short, treating simply of chilblains and frost-bite, but it is ably written and complete. Next come Mr. Howard Marsh on "Abscesses," Dr. J. T. Hogden, of St. Louis, on "Ulcers," and Dr. Moore, of Buffalo, on "Gangrene and Gangrenous Diseases," all complete and adorned with woodcuts and chromos.

Under the head of "Venereal Diseases" we next find a

complete group of remarkable essays by White, Van Harlingen and Wharton, of Philadelphia, and Sturgis, of New York. The chromo lithographs which embellish these articles are as fine as any we have seen, although the colouring is here and there perhaps a little heavy. The section devoted to "Pseudo-venereal Affections" is especially interesting. One of these affections, called the "Disease of St. Paul's Bay" is said to have appeared in Canada in the year 1760. "The disease first manifested itself in pustules on the lips, mouth and tongue; these pustules were filled with a whitish fluid which was very contagious. At a later period the patients suffered from large ulcers, glandular swellings in the groin and throat, and violent nocturnal pains in the osseous tissues, with caries of the nasal, palate, and cranial bones, and sometimes loss of sight and hearing." To our way of thinking the above is a pretty correct clinical picture of syphilis, although Dr. Stratton does not consider them identical, having observed the disease of St. Paul's Bay among the American Indians, in whom it often proved fatal.

Dr. J. C. White, of Harvard University, contributes an article on the "Surgical Diseases of the Skin and its appendages." The subjects are admirably arranged, and dealt with in a manner that will commend the article especially to the general practitioner. Dr. Joseph W. Howe, Clinical Professor of Surgery in Bellevue Hospital Medical College, New York, has been well chosen by the editor of the *Encyclopædia* to supply the next article on the "Diseases of the Cellular Tissue." This is a difficult class of diseases to handle, but Dr. Howe has succeeded in giving us a most judiciously arranged and complete exposition of the subject, and as an article for reference this will be found invaluable. Dr. C. Naucrede, of Philadelphia, contributes the last article in the volume on "Injuries and Diseases of Bursæ," and we only regret that space will not permit us to refer to it at greater length, for in our opinion, while it is the last contribution it is not by any means the least valuable.

The Hospital Treatment of Diseases of the Heart and Lungs. With over three hundred and fifty formulæ and prescriptions, as exemplified in the Hospitals of New York City.—By Charles H. Goodwin, M.A. New York: C. H. Goodwin, M.D.

We have looked through this little book with considerable interest, and have no doubt that a very large number of our readers will possess themselves of it, in order that they may do likewise. It contains information which can hardly be obtained in any other way. The plan on which it is put together tends to make the results one thus gets at very instructive. The leading diseases of the lungs, and of the heart, are classified in order, and under each one is detailed the special methods of treatment systematically adopted for its relief by each of several of the most eminent physicians of the New York hospitals. The reader thus arrives at a good deal of the unwritten experiences of these competent observers and thoughtful men. To a physician, in charge of any serious case, it cannot but prove highly instructive to turn up, in this volume, the corresponding chapter and learn the varying (or in some cases very similar) treatments which have in time recommended themselves to such men as these with ample opportunities of coming to a just conclusion as to their merits. In particular cases, also, special formulæ are given which, to one unaccustomed to prescribing, will often prove extremely useful. As far as we can judge, it gives a very fair and judicious representation of American practice in the department of chest diseases. It is to be hoped that the same author will follow this with similar works devoted to affections of other important organs and functions.

A Clinical Hand-book of the Diseases of Women.—By W. Symington Brown, M.D., Member of the Gynecological Society of Boston; Fellow of the Massachusets Medical Society, &c. New York: Wm. Wood & Co.

The number of works specially devoted to disorders of the female pelvic organs is now very considerable, and in a new hand-book on the same subject one naturally looks for its *raison*

d'être. This, in the present case, it is not altogether easy to discover. It is difficult to compress such an extensive subject into a little over one hundred pages, and yet leave much space for anything original. In spite of this, a very fair summary is given of all the various diseases included under its heading, together with the modern treatment of the same. Its chief claim, however, must be its highly practical character which is never lost sight of. Besides, whenever feasible, the writer introduces cases and observations of his own to illustrate the various points under discussion. It contains a number of illustrations, particularly of recent instruments which will no doubt be found useful.

Suppression of Urine, Clinical Descriptions and Analysis of Symptoms.—By E. P. Fowler, M.D. Ninety-three clinical cases, with illustrations, tables and diagrams. New York: Wm. Wood & Co.

The above consists of a very excellent paper submitted by Dr. Fowler to the *New York Medico-Chirurgical Society.* It contains the details of a very interesting case of anunia related by the author, and following this, an analysis of a very large number of recorded instances of complete suppression from various causes. The different symptoms are treated of in detail, and carefully-constructed tables show the varying frequency and severity of each of these. To any one interested in the subject, this monograph, which displays a great deal of research, cannot but prove very valuable.

A System of Human Anatomy, including its Medical and Surgical Relations.—By Harrison Allen, M.D., Professor of Physiology in the University of Pennsylvania, &c., &c. Illustrated. Section III. Muscles and fasciæ. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Bros.

It may be remembered that, quite recently, we drew attention to the appearance of the two first sections of this work, and expressed a very favorable opinion of its general scheme and

the manner in which it had been carried out. The above forms a continuation of the same. A critical examination of this section will show that it reaches, in every respect, the high standard attained by its predecessors. The large plates are extremely well executed, very clear and plainly lettered. The letter-press is constructed in a fashion to make the study of anatomy much more interesting than when the attempt is made to learn it from the ordinary text-book. It deals with the important matters of nerve-supply and functions of muscles with reference to the various facts of both medicine and surgery in an able and instructive manner and, when complete, it will, as a standard work, be an admirable addition to American medical literature.

Books and Pamphlets Received.

Rheumatism, Gout, and some Allied Disorders. By Morris Longstreth, M.D. New York: Wm. Wood & Co.

The Pharmacopœia of the United States of America. Sixth Decennial Revision. New York: Wm. Wood & Co.

A Treatise on Fractures. By Lewis A. Stimson, B.A., M.D. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Bros.

Legal Medicine. By Charles Meymott Tidy, M.B., F.C.S. Vols. I. and II. New York: Wm. Wood & Co.

The Laws of Life and their Relation to Diseases of the Skin. By J. L. Milton. London: Chatto & Windus.

Fourth Annual Report of the State Board of Health of Illinois. Springfield, Ill.

The Retrospect of Medicine. By W. Braithwaite, M.D., and James Braithwaite, M.D. Vol. ixxxvi., July-December, 1882. London: Simpkin, Marshall & Co.

Pocket Therapeutics and Dose Books. By Morse Stewart, Jr., B.A., M.D. Third edition. Detroit: Geo. D. Stewart & Co.

Early Aid in Injuries and Accidents. By Dr. Friedrich Esmarch. Translated from the German by H.R.H. Princess Christian. Philadelphia: Henry C. Lea's Son & Co.

Manual of Gynecology. By D. Berry Hart, M.D., F.R.C.P.E., and A. H. Barbour, M.D., B.Sc., M.B., &c. Vol. I. New York: Wm. Wood & Co.

The Compend of Anatomy. For use in the Dissecting Room and in preparing for Examinations. By John B. Roberts, A.M., M.D. Third edition. Philadelphia: C. C. Roberts & Co.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, December 15th, 1882.

R. A. Kennedy, M.D., President, in the Chair.

Dr. Gurd exhibited a patient in whom the expiratory act was of a peculiar interrupted character, the air being expelled in a series of distinctly audible jerks quite evident to the ear some four or five inches from the mouth. A condition resembling this somewhat has been described by Drummond as a diagnostic sign of thoracic aneurism, and is explained by pulsation on the trachea. The woman is healthy in every respect, and physical examination fails to reveal any condition likely to give rise to the peculiarity observed.

Dr. Mills said that he had heard slight murmurs accompanying the expiratory act very similar to this after exertion, possibly being transmitted through the medium of the trachea acting as a conducting board.

Pathological specimens exhibited by Dr. Osler.

I. *Lungs from a case of Tuberculosis of Pleura and Lungs.*—History: Mrs. McL, aged 27, admitted early in November to General Hospital under Dr. Ross. Hard drinker, early symptoms of cirrhosis of liver. Hemorrhage from bowels, no ascites, intense tenderness over region of liver. Pleurisy on both sides and signs of tuberculosis of lungs. Left lung covered with a thin fibrinous exudation, thickest at base and near the edges. In places the membrane is studded with minute granular bodies resembling tubercules, which are best seen where the exudation is less abundant. The organ is crepitant throughout, a caseous spot is seen at apex, and a narrow fibroid area in the lower lobe. No disseminated tubercles throughout the substance. The right lung presents a similar exudation, less abundant than in the left lung. At the apex is a small caseous mass with a cavity the size of an almond in direct communication with a bronchus. In the neighborhood of this are several small groups of tubercles. The lower lobe also presents

a couple of small caseous bodies, but no scattered tubercles. The costal pleura is thickly lined with false membrane, is congested, and presents small gray bodies scattered through the membrane. Liver weighs 2,200 grammes, is large and pale. Lobules distinct, bile-stained in centre. Organ is both fatty and cirrhotic. Other organs normal.

II. *Specimen of Ulceration in Typhoid Fever.*—Clinical History: I. McI., æt. 35. Attack sudden, onset marked with rigor; admitted to hospital on 7th day. Did well at first, then became delirious, and shewed signs of bronchitis. The "typhoid symptoms" set in and patient died on the 15th day. Lungs are dark-colored, full in volume, crepitate throughout; lower lobes are sodden and very heavy, and crepitate but slightly. On section cut surface shews much blood. Bronchi shew a dark mucous membrane covered with mucus. Spleen enlarged, dark and soft intestines. In the ilium in the upper part one or two small reddish spots a little elevated above the mucous surface. Only one ulcer of any size, this is about $1\frac{1}{2}$ feet from the valve. Several of the Peyer's patches are only injected, and present here and there an isolated swollen follicle. An enlarged patch is next the valve. There are a few solitary glands enlarged and capped with sloughs or presenting small ulcers.

III. *Fibroid Disease extending to the Lung from the Pleura. Cirrhosis of Lungs and Kidneys.*—A. D., æt. 33. In General Hospital under Dr. Ross. Signs of phthisis and dropsy, albumen, casts and pus in urine.

Autopsy.—Anasarca of legs, $1\frac{1}{2}$ pints of fluid in abdomen, turbid effusion in pleura, adhesions on both sides, unusually firm on the right. Heart—Organ is large, especially on the right side. Right ventricle somewhat dilated, walls firm and somewhat increased in thickness. Tricupsid orifice $4\frac{3}{4}$ in. in circumference. Aortic valves a little opaque and thick, as are also the mitral. Aorta presents a few small patches of fatty change but no atheroma. Left lung crepitant throughout lower lobe heavy and sodden; pleura of upper lobe covered with adhesions. About the middle of upper lobe a small cicatricial

spot extending from the pleura into the substance. In this is the small cavity of a dilated bronchus. Right lung small, especially at the lower part. It is very intimately adherent to the diaphragm, and the diaphragm to that part to the liver. The pleura covering the lower half of the lung is much thickened. In places nearly 1 c.m. thick, averaging about 5 m.m. The diaphragm, pleura and lung form one dense firm mass. On section through the lung the upper lobe is crepitant and healthy looking. The lower lobe presents numerous fibrous bands passing into it from the thickened pleura, constricting the lung and greatly diminishing the volume of the lower lobe. Close to the pleura the tissue is quite fibroid and airless. In the deeper parts the tissue between the fibroid septa still contains air. The organ presents a beautiful example of fibroid disease extending to the lung from the pleura. Spleen a little enlarged; pulp soft; kidneys small; capsule detaches without difficulty; surface irregular, and presents numerous coarse granules and several cysts. On section organs are firm. Cortex much reduced, in some places only 2 m m. thick. It is pale, and presents a few opaque spots. The pelvis of the left kidney is in a state of inflammation extending into the calices. Liver closely adherent to diaphragm. Presents a small fibroid area at a spot corresponding to the fibroid disease of the lung. Substance pale and a little tough, but presents no marked alteration. Nothing of note in other organs

Dr. Alloway exhibited *a placenta, removed by the Uterine Curette*, with the following history: Patient aged 41, married 20 years; has had 10 children at full term, and 4 miscarriages (2, 3, 5 and 5 months respectively), 14 pregnancies in all. She is now in her 5th month of pregnancy; has had metrorrhagia for the last five months with occasional pain. On the 10th inst. Dr. Alloway was sent for. Found membranes protruding through the os, with the embryo contained within. The internal os was fairly well dilated, but could not introduce finger beyond it, notwithstanding the use of considerable pressure outside in an endeavor to force the uterus low down in the pelvis. The pain would have been intense without an anæs-

thetic. The embryo was removed. No protruding placenta could be reached with the finger, but concluded it must be firmly attached to the uterine wall. So firm and complete were the adhesions that considerable difficulty was experienced in endeavoring to find a part sufficiently detached to insert the curette. When this point was gained the whole was detached without any further difficulty. During the operation the patient was placed across the bed on her back, with her feet resting on Dr. A.'s knees. No pain whatever was experienced, and the operation occupied about twenty to thirty minutes. The patient was placed on ℞ x Ext. Ergot fld. three times a day. Recovery was complete in ten days. Dr. Alloway remarked that his chief object in exhibiting the specimen was to point out the complete form of the placenta removed and the fibrous condition of its tissues. That the embryo must have been dead seven or eight weeks judging from its size, and the utter impossibility of the uterus being relieved of its contents without the aid of the curette or an anæsthetic. That the use of the tampon and the expectant plan of treatment would have ended in septicemia and probably loss of the patient's life.

Dr. Trenholme urged the great value of the finger, and preferred it to any instrument. By hooking the finger over the inner os, and pressing down over the fundus externally, almost every case could be easily managed; in fact, he had never met with a case where the finger failed to remove any adherent placenta in early abortions. Where the abdomen was difficult to depress, chloroform gave perfect command of the patient. In this connection Dr. Trenholme remarked that he had a case where the dead fœtus was retained as a similar tumour for six or seven months, the woman having monthly hemorrhage until it was removed. This form of hemorrhage during gestation is due to non-union between the *reflex* and *uterine* deciduæ.

Dr. Gardner testified to the value of the vulsellum. In many cases it is very difficult to force the uterus sufficiently low down, and it is much more easily brought within reach by fixing one lip with the vulsellum, and then drawing the uterus down. He had never used the curette. As a rule he can succeed per-

fectly with the finger, which he prefers to the curette, but no doubt cases will occur where the removal of the attached membranes is facilitated by the curette.

Dr. George Ross said that it was most important that an anæsthetic should be administered, after which the uterus can be forced down with comparative ease in many cases where otherwise it would have been quite impossible ; he also spoke of his preference for the finger as compared to the curette in these cases.

Dr. Cameron was opposed to Dr. Alloway, who invariably uses ether as an anæsthetic, but thought chloroform was much better, and spoke of a case where, owing to the rigidity of the parts from the former, the removal of the contents of the uterus was rendered impossible until chloroform was used, when it was easily affected.

Dr. F. W. Campbell also spoke of the advantage of the finger over the curette, and of the assistance rendered by the use of the vulsellum.

Dr. Fenwick exhibited the portions of bone removed at an operation for excision of the knee-joint performed by him that day. The patient, aged 21, gave an account of an acute synovitis in the knee-joint twelve years before, following cold or some very indistinct injury, and frequent attacks of more or less severity ever since. On consulting him the joint was swollen, loose and tender, and there were severe starting pains at night. At the inner side of the head of the tibia it was very tender, and possibly the disease commenced in the periosteum at that point. On cutting into the joint, the semilunar cartilages were found destroyed and the cartilages of the femur gone ; erosion of the bones, and a fringed condition of the synovial membrane. The usual form of operation was followed, rounding off the end of the femur and hollowing out the tibia ; not more than $1\frac{1}{4}$ inch of bone was removed. Dr. Fenwick remarked that the great advantage in children was to save the epiphysis, and thus benefit by the growth of the bones.

Dr. Mills explained the method of demonstrating the urinary pigments, and exhibited specimens illustrating the different steps

in the process, which latter are as follows: About 50 c.c. of urine suffices to show the reactions clearly. 1. Urine treated with strong solution of acetate of lead and a few drops of ammonia and filtered. 2. Pasty mass remaining on filter treated with strong sulphuric acid and a little alcohol and filtered. 3. To the yellow filtrate is added excess of strong sulphuric acid and boiled. 4. The resulting dark fluid is then diluted with a large excess of water, and allowed to stand; a flaky black precipitate (very soluble in ammonia) deposits. This is diromelamine, a resultant product of the decomposition of urochrome.

Dr Gardner then read a paper on *Cases of Procidentia Uteri*, with the view of giving an account of the experience he had had at the University Dispensary and in private practice of this condition, illustrating its nature and treatment. He included under the head of Procidentia Uteri those cases of elongation of the supra-vaginal cervix, with protrusion or descent of the vaginal wall through the vulva. In a large majority, 10 out of 13 of the cases reported, this condition was present. As to the nature of this elongation, he thought there could be little doubt of its being in the main due to a "tensile elongation," as Matthews Duncan calls it, of the supra-vaginal portion of the cervix through primary descent of the vagina and bladder, and in some cases leading to a remarkably extreme degree of elongation and thinning of this portion of the cervix. Huguier, who was one of the first to call attention to the subject, held it to be a true hypertrophy, "Allongement Hypertrophique du col de l'Uterus," but from facts adduced from the experience of Fritsch, and from the cases cited by the reader of the paper, such a view would seem to be disproved. The great majority of the cases reported occurred in women from six to sixteen years past the menopause, and in whom senile involution, as well as stretching, was a factor in the production of the condition. The opinion that it is a stretching is also borne out from experiments on the cadaver; and, furthermore, on the living subject, when the parts are replaced and retained, and all traction force removed, the stretched cervix in a short time retracts, becomes shorter and thicker. In regard to the treatment of Procidentia Uteri by surgical mea-

sures, Dr. Gardner held that although valuable, as such operations were in certain cases, yet they were often unnecessary and inexpedient, always uncertain in their results, and in some cases positively dangerous; and while thousands of women can be so thoroughly relieved of their symptoms by pessaries, they will not listen to any proposal to perform an operation. Dr. Thomas of New York states that in a certain number of cases where traction of the prolapsed vagina, rectum or bladder is the cause of the uterine displacement, operation should be the chief resource; but if a heavy uterus presses down of its own weight, or is forced down by pressure from above, closing the perineum or contracting the vagina by colporrhaphy is illogical, unncessary and empirical. In reference to the many forms of pessaries in use to keep the prolapsed uterus within the pelvis, the great principle to be observed is that they fulfil their purpose with as little distension as possible of the vagina. The Gehrung pessary, with which he (Dr. Gardner) has had most experience, was found to answer admirably in a number of cases, and fulfil, in an important way, the above-mentioned general indication in the use of pessaries. It supports the cystocele very effectually, and in this respect has no equal. One objection, however, from which it is not free is that it interferes with marital relations, but that it does not positively prevent coitus is shewn by instances of conception in patients wearing the pessary.

In reply to Dr. Campbell, Dr. Gardner remarked that he used and believed in the utility of tampons soaked in an antiseptic and astringent solution, such as that recommended by Bell of Glasgow in the treatment of recent cases of prolapse of mild degree. Intravaginal pessaries were in many cases quite ineffectual where the object in view might be attained by a pessary with an external support, such as the Cutter cup or ring.

In reply to a remark from Dr. Trenholme, to the effect that he preferred the Hodge to any other pessary, Dr. Gardner said he believed that there were cases in which the Hodge retained the parts, but there were others in which it failed, where the Gehrung pessary succeeded admirably. It fulfilled one important indication, viz., that it supports the cystocele much better than

any Hodge pessary could, without unduly distending the vagina. In reply to questions from Dr. Roddick and others, Dr. Gardner said he would certainly operate in suitable cases, such as those in which pessaries were not borne; when the patient was past the child-bearing period; when the uterus was not inordinately heavy, and therefore likely to again force its way gradually through the narrowed vagina; and when the patient's general health was good enough to warrant reasonable expectation of primary union; and, lastly, when the patient could spare the (sometimes quite considerable) necessary time.

Stated Meeting, December 29th, 1882.

Dr. Henry Howard in the Chair.

Cases in Practice.—Dr. Hingston exhibited a patient suffering from necrosis of the upper jaw, contracted from long exposure to the influence of phosphorus in the match works of Messrs. Eddy & Co., of Hull, Ont. The patient, a middle-aged man, had worked in the factory since six years of age, but the first evidence of infection was only six months ago, since which time the progress of the disease has been rapid. There is now complete necrosis of the alveolar processes of the upper jaw, with absence of the teeth and swelling and tenderness of the right side of the face from local periostitis. The lower jaw is healthy in every respect. Dr. Hingston spoke of the comparative rarity of these cases reported as occuring in the establishment of Messrs. Eddy & Co., and also of the fact of the lower jaw in this case being unimpaired, whilst the disease is generally spoken of as being peculiar to this bone.

Dr. Trenholme mentioned a case of necrosis of half of the lower jaw in a boy addicted to chewing matches.

Dr. Shepherd spoke of a case under the care of Dr. Macdonnell, the cause of which had been ascribed to the habit of burning matches in the mouth by a boy, showing how peculiarly susceptible some were to the influence of phosphorus.

Dr. F. W. Campbell reported a case of pyæmia. The patient, an elderly person, during the past summer was poorly, and

complained of flying pains in his feet, left the city, and returned about six weeks ago ; pains continued. At this time the cuticle under the great toe and the heel was slightly raised. On puncturing these points a watery fluid escaped, and the under surface of the big toe and a small portion of the little toe presented a small spot having a decidedly gangrenous appearance. He kept going about, and was actively employed till he had a severe rigor. Matter subsequently formed at the heel, which on evacuation was offensive and fetid. From this time there were repeated rigors. From the gangrenous spot a line of inflammation extended up over the instep and the inner side of the leg to the knee. A gangrenous looking spot at the instep disappeared on the application of poultices, but the condition at the toes remained unaltered, and shewed no tendency to spread. The arteries were hard and atheromatous. Cerebral symptoms soon set in, and the patient rapidly sank.

Dr. Hingston had met with many cases of gangrene, senile gangrene and other forms of the disease. In his opinion senile gangrene (although generally looked upon as fatal) is less dangerous than that of middle life ; he had seen toes, and even half the foot, drop off, but in this form a small blush may indicate a fatal termination. He spoke of a case he had been consulted about last summer, in a man of 54 years of age, commencing in gangrene of the small toe, which seemed trifling, only involving the first joint; in consequence of this an operation was postponed. In five or six days the whole toe was dead and half of the next toe ; the matter was burrowing. No pulsation was felt in the artery as far up as the popliteal space. Amputation was then performed above the knee, and ½ an inch below the amputated part the artery was brittle like glass, and half way down the leg was blocked by a clot. The patient died from exhaustion in 36 hours. Dr. Hingston said that the gangrene of old age begins without and extends inwards, whereas in that of middle life it shows itself in the skin last. The gravity of the case seems to be in inverse ratio to the age of the patient.

Dr. Howard spoke of the frequency of gangrene in the insane.

In regard to the greater gravity in cases of gangrene occurring in middle life it might be explained by the greater power of absorption in these individuals.

Stated Meeting, January 12th, 1883.

Dr. T. G. Roddick, Vice-President, in the Chair.

A paper was read by Dr. Osler on *Parasites in the Pork Supply of Montreal.* (This paper appeared in the January number of this Journal.)

Alderman Mooney asked if animals affected with trichinæ showed any appearance to indicate it either before or after slaughter.

Dr. Osler replied that the presence of trichinæ cannot be made out without the use of the microscope. The hog suffers comparatively little when fed with trichinous food, beyond slight fever and slight gastric irritation. No other disturbance is seen.

Dr. Bessey expressed surprise at this, as he believed the general opinion was that such animals are meagre, and do not fatten and give other indications that something is wrong.

Dr. Larocque believed the reason why "trichiniasis" is less common here than in the West, is that here hogs are fed more on grain, whereas in the West they are allowed to roam about.

Alderman Mooney said the Board of Health were doing all in their power to secure rigid inspection in this matter, and had recommended to the Council the appointing of Veterinary Surgeons for this purpose, but owing to the want of means no appropriation had been made. However, they have secured the services of experienced persons who have acted as inspectors, and the result has been very satisfactory so far, and they intend making the inspection still more complete.

Dr. Osler, in reply to Alderman Fairbairn, said it would hardly be worth the expense on the part of the city to insist on microscopic examinations being carried on at the abattoirs, as it would require two inspectors to attend to nothing else. In Germany the hogs, and the specimens examined, are carefully

labelled, and thus the diseased animals are known and can be confiscated. Trichiniasis is less common here, from the fact that the cooking is more thorough. If examinations were made an epidemic might ultimately be averted. In the hog the presence of trichinæ is borne in a remarkable manner, and the cyst walls are never so dense, nor do they become calcified as in man. The symptoms in the hog have been carefully studied, and nothing has been found beyond slight fever and slight gastric disturbance, even in extensively infested animals. Sometimes in very extreme cases there is seen slight stiffness in the joints, but the hog has great powers of resistance, and as a rule very few symptoms are observed.

Mr. Radford, Sanitary Inspector, said great benefits had resulted from the inspection of meat at the abattoirs, but for further powers, which were necessary, an amendment to the city charter would be required.

Mr. Boxer said that after the meeting of the medical deputation in Ottawa, a Sanitary Association was formed, and it is the intention to establish a Sanitary Journal, in which lectures such as this could be published, and prove of great interest to the general public.

Mr. Bickerdike said the specimen of measley pork exhibited was the first he had seen for ten years, although a great many were seen before that time when the animals were allowed to feed at large. The inspections at the abattoir are being carried on in a very satisfactory manner, the inspectors being all practical butchers.

Dr. Trenholme spoke of the practice of driving cattle and killing them while in a heated condition, and also of the practice of killing them by shooting. The meat of animals killed in this way could not be other than injurious.

Mr. Bayard, Inspector at the Montreal Abattoir, mentioned several instances of disease in animals inspected by him. He had that day met with an instance of extensive disease in a cow, and had taken the liver to Dr. Osler for examination.

Dr. Osler said that the specimen was one of extensive tuberculosis, or consumption, and he had brought it for the inspection

of members. An important question was whether the flesh and milk of consumptive animals could communicate the disease to man. Many authorities thought it possible, but the evidence was as yet scarcely conclusive. The public, however, should get the benefit of the doubt, and the flesh of consumptive animals should be confiscated.

Extracts from British and Foreign Journals.

Unless otherwise stated the translations are made specially for this Journal.

The Use of Tobacco by Children.—Considerable attention is being paid both in the medical and lay press to the subject of tobacco-using among young lads. A well-known female correspondent has made the statement that seventy-five per cent. of school-boys over twelve or thirteen years old smoke cigarettes probably without the knowledge of their parents, but not unknown to the teachers. She says further that the principal of one of the largest private schools in the country assured her of its pronounced evil effects upon his boys, but that he was so convinced of the firm hold the habit had gained upon them that he considered it as time thrown away to remonstrate or interfere with it. The principal of a grammar school in a neighboring city found on investigation that of the boys under his charge, in age from eight to fifteen, four fifths confessed to using tobacco in some form. The deleterious effects of the drug in arresting the development of children are sufficiently known, but perhaps their importance is hardly realized. A correspondent of the *British Medical Journal* describes a case in which arrest of growth in the organs of generation seemed to be due to this cause. He was twenty-five years of age, and five feet nine inches and a half in height. His penis was small and the prepuce rather long, but not in a condition of phimosis. The testicles were remarkably small, neither being larger than a French bean, or, perhaps what more nearly expresses their size and shape, no larger than the testes of a rabbit. The scrotum was not relaxed, nor was there any varicocele. There was short

dark hair on the pubes. The voice was somewhat high pitched, yet not like that of a woman or eunuch. Though twenty-five, he had not a trace of beard, whisker, or mustache; nor was there any hair on the chest or around the nipples. The breasts were flat, yet the contour of the lower extremities and lower part of the trunk resembled that of a woman more than that of a man. In observing this man one could but be struck with the evidence of development on a manly type up to a certain period, and then of a cessation of further virility. His manly height and muscular development ill accorded with the entire absence of beard and weakness of expression. In these respects he differed from the short, rounded, plump eunuchs produced by robbing children early of their testicles. In searching for a cause of this arrest of development, we ascertained that he had not suffered from mumps, nor from any inflammation of the testes. There appeared, indeed to have been no disease which could have checked the growth of these organs. He, however, stated that he was an inveterate tobacco-chewer, preferring a good "quid" to victuals; and that he commenced this habit at the early age of nine, by stealing from his father's pouch what he could not afford to buy. His mouth, at the time of examination, was occupied by a "plug," and there was further evidence of the habit in the staining of the teeth where the dentine was exposed. In the absence of any other cause to which this condition of generative organs could be referred, the writer was inclined to attribute their arrest of development to the poisonous effects of excessive chewing of tobacco.—*Boston Medical and Surgical Journal.*

Cosmoline and Petroleum in Diphtheria, Hooping-Cough and Measles.—Dr. Harvey L. Byrd, in the *Medical News*, says: I have been using petroleum locally to the throat for some time past, while administering cosmoline internally, as a remedy in diphtheria. They are both remedies and prophylactics in this terrible scourge. I administer cosmoline alone in alternation with lac sulphuris, or in conjunction with it, in eight to fifteen-grain

doses of each, according to the age of the child, every two or four hours, while petroleum is applied to the throat externally. But while I regard it as the chief factor in producing relief in diphtheria, the gravity of the disease is such that I have refrained from relying upon its internal use to the exclusion of other remedial agents. I recommend the administration of cosmoline twice a day to the well children of a family, as soon as called to a case, with the result of protecting all those from the disease who have taken it. Its action has been highly satisfactory in hooping-cough and measles. Cosmoline will lessen the violence of the paroxysm in hooping-cough, and loosen, as well as lessen, the mucus promptly, and it mitigates the violence of the attack and shortens the general course of the disease.

Treatment of Ringworm of the Scalp.—Dr. Tom Robinson writes as follows concerning the treatment of this usually very intractable affection: "In ringworm of the scalp, I always refuse to treat the case unless the child has the head shaved, believing it to be impossible to bring any remedy into contact with the fungus unless this be done. I then direct the scalp to be well washed with a liquid made by dissolving one drachm of the Pharmacopœia soft soap and half a drachm of carbonate of potash in twelve ounces of orange-flower water. After this is done, I direct my patient to wear a piece of lint covered with oil-skin continually for a week, which lint is saturated every two hours with the following solution:

Hydrarg bichloridi	gr.	vi.
Acidi carbolici	ʒ	i.
Sp. vini rect	ʒ	vi.
Glycerini	ʒ	vi.
Aquæ	ad ʒ	xi. Misce.

"After this has been earnestly carried out, I am sure the disease will but in few instances give further trouble. The rings will probably be scaly for some time afterward; but if the head is kept clean and the nitric oxide of mercury ointment of the Pharmacopœia used at intervals, the normal appearance will be resumed."

Varicose Veins.—The patient was an old man with beautiful examples in both legs. Since in the right leg there existed some phlebitis, it was not operated on, in the hopes that the inflammation might prove sufficient to obliterate the veins. On the right side the operation was done, without an anæsthetic, as follows: A piece of carbolized cat-gut, carried in a large curved needle, was passed through the skin about half an inch from the course of the vein and brought out at an equal distance on the other side. In this stitch the cat-gut passed under the vein. The needle is then re-introduced at the place of its exit and carried backwards between the vein and the skin, and made to emerge as near as possible to the place where it entered. The cat-gut is then firmly tied and the ends cut off, so that if possible the knot shall disappear under the skin. A dull needle is preferred by the operator, as the point is not so likely to emerge at an undesired place. The spray is used and a complete Lister dressing placed over the site of the operation. In this case the veins were tied in four places, one of which was above the knee, and the patient kept quiet in bed for a few days. It is claimed that this method has been very successful and the dangers are far less than by any other operation. It certainly has simplicity and ease of accomplishment to recommend it.—*The St. Louis Med. and Surg. Journal.*

Grunberg on a Case of Obturator Hernia —The subject of this case, reported by Dr. Grünberg of Stralsund (*Deutsche Zeitschrift für Chirurgie*,, Band xvii, Heft 1 and 2), was a woman aged sixty-five, who, during the three days before she came under observation, had suffered from well-marked and very intense symptoms of intestinal strangulation. No swelling could be made out at any of the usual seats of hernia, but on close examination it was found that pressure just below the left groin and over the pectineus muscle caused great pain. A vertical incision, about three inches in length, commencing just below the horizontal ramus of the os pubis, was carried downwards, at a distance of an inch and a quarter from the outer border of the adductor longus. On

exposure of the surface of the pectineus, no swelling nor abnormality was observed; but on raising the outer margin of this muscle, and drawing it inwards, a hernial tumor of the size of a large hazel nut was revealed. After incision of the wall of the sac on a director, a small loop of intestine came to view, which though very lightly constructed, and of a dark blue colour, presented a smooth and shining surface, and had evidently not became gangrenous. For fear of wounding the obturator artery, the pulsations of which could be felt by the finger, the knife was not used for overcoming the stricture. The orifice constricting the neck of the hernia was dilated by the fore-finger being carried along the outer and lower portion of its circumference, and also by breaking down some of the fibres of the obturator membrane. All the symptoms of strangulation ceased immediately after the operation, and on the eighteenth day the patient, though feeble, was regarded as cured. Two days later, however, according to postscript to this report, she died suddenly with symptoms of collapse, in consequence of perforation of intestine. Dr. Grünberg states that it is not clear to him why almost all the writers on obturator hernia have reported its diagnosis as being very difficult. He holds that the diagnosis of a strangulated obturator hernia is not more difficult than that of a strangulated femoral hernia. No tumor, it is true, is to be seen or felt, but then there is always characteristic pain. In some instances there is lancinating pain caused by pressure on the obturator nerve. In Dr. Grünberg's case any attempt at active flexion of the thigh excited very intense pain, and the patient complained of constant painful and pricking sensations extending down the inner side of the thigh. This pain, due to pressure on the nerve, however, is not always felt in cases of obturator hernia, and is frequently complained of by the subjects of uterine disease, and also by hysterical women. The characteristic pain of strangulated obturator hernia, and that by which the diagnosis may be readily and surely established, is the tenderness complained of when pressure is made over the pectineus muscle. This tenderness, the region of which is very limited in extent, is so intense that the patient screams

when it is excited, and, if under the influence of an anæsthetic, shrinks on pressure over this tender part. When this characteristic pain over the locality of the obturator canal can be made out in association with symptoms of intestinal strangulation, Dr. Grünberg holds that one may safely diagnose obturator hernia. On the other hand, in absence of such pain he would decide with equal confidence against the existence of this affection. Notwithstanding the success that attended non-operative treatment in the well-known case reported by Roser in 1845, Dr. Grünberg would not expect much from taxis in any case of strangulated obturator hernia; the hernial tumor is so very small, and reflex contraction of the surrounding muscles is so liable to be set up on manipulation. If not strangulated, the hernia might return spontaneously under the influence of alternating natural contraction and relation of the adductors and flexors of the thigh. The operation for relief of the hernia, when strangulated, if performed early, is free from danger. Dr. Grünberg recommends that in order to avoid bleeding from the muscular vessels, the pectineus, instead of being partially divided, should be raised, and then dragged towards by blunt hooks. Should the hernial tumor be large, so as to necessitate division of the muscle, it is recommended that it be separated at its origin from the ramus of the pubis by the use of a tenotome. The constriction, it is held, may usually be overcome by passing the tip of the fore-finger with a gentle boring movement between the neck of the sac and the membranous portion of the constricting ring, dilatation being effected partly through yielding of the obturator membrane, and partly through the tearing of some of its fibres. Hæmorrhage from the obturator artery will thus be avoided. If the superficial incision be made according to Dr. Grünberg's directions, there is no danger, he says, of wounding the internal saphenous vein. The incision he recommends is one about three inches in length, commencing just below the horizontal ramus of the pubis, at a point about one inch and a quarter to the outer side of the origin of the stretched adductor longus, and carried downwards over the outer margin of the pectineus.—*W. Johnson Smith in London Med. Record.*

The Organisms of Typhoid.—Maragliano of Genoa has published in the *Centralb. fur die Med. Wissenschaft.* an important note on the uniform occurrence of organisms in the blood of patients suffering from typhoid. He has found them in the blood of the spleen as well as in that of the general circulation. The blood was obtained by means of a hypodermic syringe, the needle of which was passed through the abdominal wall into the substance of the spleen. Dr. Sciamano of Rome first showed that blood may be thus obtained from the substance of the spleen during life without any injurious consequences. The blood of the general circulation was taken from the tip of the finger. In each method every precaution was taken to avoid the accidental introduction of organisms. The examination in this way of 15 patients gave the following result. At the height of the disease the blood of the general circulation contains micro-organisms both isolated and grouped. These consist, almost exclusively, of spherical bodies, which have a delicate contour, appear to be homogeneous, and are analagous to micrococci. Some of them are mobile. Similar organisms, again, were seen in the blood of the spleen, and in it, too, were others, rod-shaped, also with delicate outlines, perfectly corresponding to those described by Eberth and Klebs. During convalescence these micro-organisms lessen in number in both the splenic and systemic blood. When quinine was given to the patient in large doses the organisms either disappeared from the blood or were present in it only in small number. The blood from both the finger and the spleen was treated by the method of fractional culture, and a large number of rods were then obtained, similar to those seen in the fresh blood, except that some of them were of greater length. The presence of such organisms in the blood of the spleen after death had been previously established by Sokoloff and Fischel, Maragliano is the first who has demonstrated their presence in the splenic blood during life. He avoids the expression of any opinion as to their relation to the disease.—*Lancet.*

Cardiac and Pericardial Murmurs.—Dr. J. Lynch, before the Medical and Clinical Society of Mary-

land, presented a paper in which he gave a new point in the differential diagnosis of cardiac and pericardial murmurs. He says: "Whenever a friction murmur is produced at or near the heart's apex (the only condition in which there will be any serious difficulty in the diagnosis), if we cause the patient gradually and slowly, but entirely, to inflate the lungs, we will perceive that the friction murmur becomes progressively more intense until the act of insufflation is complete. Now make the patient hold his breath while the lungs are in the state of complete insufflation, and the murmur will be steadily maintained at its maximum intensity. Cause him then to expire in a like slow and gradual manner, and the murmur will be found to decline in intensity, until the minimum will be reached at the completion of the expiratory act, at which it will be maintained until another inspiration increases intensity. The murmur does not entirely disappear, however. It is present at all stages of respiration, but always presenting the variations in its intensity."

Relief of the Pain of Cancer.—M. Angen (*Union Med.*) prescribes a lotion of one part of sulphate of atropia to one thousand parts of distilled water. Compresses wetted with this solution are applied to the painful part and covered with oiled silk or gutta percha, renewing them three or four times daily. They give material relief to pain without causing symptoms of absorption, such as dilatation of pupils or dryness of throat. The action seems to be entirely local, consisting in contraction of the vessels with diminution of sensibility.

The Odor of Iodoform.—Having tried nearly all the devices that have been suggested for mitigating or disguising the odor of iodoform, and found them all of little or no avail, we have lately come nearer to the object by using oil of eucalyptus, according to the following formula: ℞ Pulv. iodoform, ℥ ss.; Ol. eucalypti, f ℥ ss.; Vaselin, ℥ iv.; M., fiat unguentum. We do not remember to have seen any account of the oil having been used for this purpose by others. The ointment thus prepared is not without odor, but the odor is not that of iodoform.—*N. Y. Med. Jour. and Obst. Rev.*

Pulmonic Surgery.—Dr. Koch, of Dorpot, communicates (Deutsche Med. Wochenschr, 1882, No. 32) the results of two cases in Leyden's clinic in which he has operated for chronic putrid bronchitis with bronchiectasis. The first case was that of a man, aged twenty-four, with the physical signs of contraction of the right lung cavities in the right base, and catarrh of the right apex. The sputum indicated gangrene of the lung and was unaffected by treatment. June 30th, part of the right sixth rib was resected, and the two layers of pleura being completely united, the thermo-cautery was gradually pushed through the lung to the mediastinum. It opened a cavity of the size of a child's fist about three fingers breadth from the surface of the lung. The sputum expectorated sank at once from four hundred to one hundred and twenty centimeters daily. June 30th, part of the eighth rib was resected and the thermo-cautery passed through the base of the lung, without, however, entering any considerable cavity. Exploratory puncture with a syringe showed a purulent collection in front of the vertebræ; and on July 11th this was laid open, between the eighth and ninth ribs, below and internal to the angle of the scapula. The condition of the patient at date of publication (Aug. 25th) was not satisfactory, although the expectoration had not quite ceased, and it was proposed to explore still further the base of the lung. The second case, a woman, aged twenty-nine, was brought into the hospital with jaundice, and the putrid expectoration amounting daily to between eight hundred and one thousand cubic centimeters. After a preliminary aspiration of the right thoracic cavity on July 15th, four inches of the sixth rib were resected, and, a hollow needle having been passed through the anterior axillary line, in the direction of the right auricle of the heart, the thermo-cautery was pushed in the same direction. Two inches from the surface of the lung it entered a cavity, about the size of the closed fist; and in pushing it upward and backward from this cavity as guided by exploratory puncture, it entered another cavity, of the size of a child's head, and containing one thousand cubic centimeters of putrid fluid. The

cavities were washed out with thymol solution and three thick drainage tubes inserted. The patient collapsed after the operation, but remained alive for a week, during which time the expectoration was completely absent, and upon post mortem the surfaces were found covered with healthy granulations. The cause of death was less the operation than a phlegmonous inflammation of the portal vein, a lobular broncho-pneumonia of the base of the left lung from the presence of a foreign body, and a chronic septicæmia which had existed for some time. The writer promises a further communication on the subject, in conjunction with Dr. Heller, who is at present making extensive operations in Leyden's clinic. Meanwhile, he considers that operative interference is indicated in cases of single cavities, especially if near the surface, in cases of acute gangrene, and in rare cases of lung tuberculosis.—*Chicago Med. Review.*

Abortive Treatment of Gonorrhœa.—Mr. N. Watson Cheyne, (Lancet, August 12, 1882) sums up the results of investigation of abortive treatment of Gonorrhœa as follows: The use of one or two iodoform and eucalyptus rods, an injection of sulpho-carbolate of zinc, and the internal administration of copaiba—has the effect, in the majority of cases of acute gonorrhœa, of checking the acute symptoms in a day or two, and bringing the disease rapidly to the chronic stage, thus avoiding all the risks dependent on the violence of the inflammation. As injections are not apt to penetrate sufficiently far, and as their effect is only momentary, he combines the above substances with cocoa butter, and makes them up in the form of solid rods about 4 inches or 5 inches in length, and about the thickness of No. 10 catheter. These rods weigh forty grains each, and each contains five grains of iodoform and ten minims of eucalyptus oil. They are dipped into eucalyptus oil, introduced into the urethra, over the orifice of which a pad of boracic lint is applied, and outside this is a large piece of gutta percha tissue, the whole being fastened on by strapping, and retained for four or five hours, if possible. The cocoa butter soon melts, and a solution of iodoform in eucalyptus oil

bathes the mucous membrane for some hours. The discharge at this time is very amenable to treatment, and gets rapidly well under the use of the above. All that he claims for the method, however, is that it cuts short the acute stage in the great majority of cases, and thus the patient escapes the dangers and pains incident to that stage. The essential parts of the method are the use of the bougie and the injection, but the rapidity of cure is much aided by commencing the use of copaiba or sandal oil at once. The method may be employed at any stage of the disease, but in his experience, it is only of use before or during the acute stage, up to (say) the eighth day. The result is the more marked, the more acute the inflammation, the rapid subsidence of the inflammatory symptoms being very striking. The addition of bichloride of mercury, though a powerful antiseptic, to the rod, or its use in the form of an injection, does not seem to be of advantage. It is possible that the combination of counter-irritation with this method may yield even more rapid and satisfactory results.

Treatment of Puerperal Mastitis by Iodide of Lead Ointment.—The breast being thoroughly dried and perfectly cleansed, we smear its surface with the officinal ointment of the iodide of lead, and then gently rub it until a considerable quantity is absorbed. Soak a piece of sheet-lint, of a size sufficient to cover the breast, in the following solution: acetate of lead, from ʒij to ʒss to the pint of a one-to-four solution of alcohol. If we desire a more elegant preparation, eau de cologne may be substituted. If there be much pain, it is often useful to apply an ice-bladder upon the sheet-lint covering the breast. The lint should be frequently dipped in the lead lotion. The following phenomena will present themselves: first, a cessation of pain, fulness and uneasy feeling of distension, which is so annoying. It is common for the patient, who has been exhausted by pain, and consequent loss of sleep, to fall into a refreshing slumber soon after the application is made. In the course of three or four hours, the breasts may be completely emptied by an experienced

hand. The ointment should be used as a lubricant during the manipulation. By applying the iodide freely twice, or thrice, daily, the secretion will be gone in less than one week, as a rule. The pivotal point in the treatment is the use of this ointment; the evaporating lotion, and cold being the only adjuncts. I have proved by repeated trials that, when applied alone, it is capable of exerting an absolute control over the secretion. I believe we here invoke a specific action from the lead iodide. A point of considerable moment is the partial anæsthesia it is capable of inducing, which thus enables us to empty the glands, where before even slight pressure was hardly borne. Its action without doubt extends to the epithelial cells and inhibits their secretory activity, as is seen in its action, in cases like the above, in causing the drying up of the secretion. * * * * A word as to the use of belladonna. I must confess that I have met poor success from its employment. My experience may have been exceptionally unfortunate, but reasoning from it alone, I could not recommend it as capable of accomplishing more than the expectant treatment.—*Dr. Thomas T. Gaunt, in American Journal of Obstetrics*, October, 1882.

Remarkable Surgical Operation.—The Paris Academy of Medicine was yesterday informed by the operator that the young man on whom an operation was performed for the extraction of a spoon from his stomach has completely recovered from the effects of the hazardous operation, and is now enjoying his usual health. Interesting particulars are given of this operation, which was performed by Dr. Felizet. By the use of the Faucher tube introduced through the mouth the stomach was cleansed prior to the novel operation, which prevented the risk of peritonitis. An incision was then made in the epigastric region. In order to render the coat of the stomach easily accessible, M. Felizet employed the following contrivance: To the end projecting from the man's mouth he fitted a spherical vessel containing ether. This he heated by submersion in water of sixty degrees temperature. The ether vapor rushing through the tube filled the stomach, which, be-

coming distended, was brought forward to the wound effected by the operator's knife. The spoon was thus readily found and extracted. It measured over nine inches. It had been accidentally swallowed by the man, a waiter at a café, in the attempt to imitate the feats of the famous sword-swallower.—*Paris Correspondence of the London Standard,* October 7th.

Frequency of Disease of the Sexual Organs in Insane Women.—Dr. Danillo examined 200 insane women, and found that 162, or 80 per cent. were suffering from various diseases of the sexual organs. Out of 140 menstruating women, between 15 and 45 years of age, only 20 were without some uterine anomaly. Out of 60 women who had ceased menstruating, between 42 and 75 years of age, 18 were the subjects of some affection of the genital organs. Acute and chronic endometritis and metritis were most frequently observed; less frequently displacement of the uterus, dysmenorrhœa, acute and chronic ovaritis, and other diseases. The above results show that the complications of psychosis with uterine disease is a frequent occurrence, and of the greatest clinical interest.—*London Med. Record.*

Albumen in the Urine.– Dr. George Johnson, F. R. S., of London, is now using picric acid for the detection of albumen in the urine. This test was suggested to him by his son, Mr. G Stillingfleet Johnson, who has long labored at chemical research, and believes that the test is free from fallacy. A saturated solution of picric acid has a specific gravity of 1003, and immediately coagulates any trace of albumen which may be present in the urine to which it is added. The delicacy of the test is strikingly demonstrated when slightly albuminous urine is poured on to the surface of nitric acid and the picric acid solution is added on the surface of the urine. An obvious advantage of the test is that the powdered picric acid may be so conveniently and safely carried in the pocket ready for the immediate and efficient examination of any urine suspected of being albuminous. It is only necessary to throw some of the

powder into the suspected urine while it is warm, and to agitate slightly, in order to produce an obvious cloudiness if any albumen be present.

Ovariotomy.— In a paper entitled "Notes on Abdominal Surgery" (*Dublin Jour. Med. Sci.*, Nov., 1882), Mr. Wm. Stokes sums up the following propositions in reference to ovariotomy :—

1. That the mortality of the operation has been and is largely diminished by Listerian antisepticism, which should therefore, in all instances, be employed.

2. That the strength of the carbolic spray should never exceed 1 in 40, and the solution in the steam-spray producer should be warmed previous to use.

3. That, in order to get with greatest facility a warm, even aseptic atmosphere and the least disturbance, the operation should not be undertaken in the operating theatre of an hospital, but in a moderately-sized ward, which should be given up for the time exclusively to the patient and her attendant.

4. That the intra-peritoneal method of securing the pedicle is to be preferred to the clamp.

5. That the "toilet of the peritoneum" should in all instances be carefully carried out.

6. That drainage should be recognized as one of the most essential features in the after treatment of ovariotomy cases.

7. That the existence of extensive peritoneal adhesions does not appear to influence unfavorably the results of the operation.

8. That in forming an estimate of the probable results of ovariotomy, a greater value is to be attached to pulse than temperature curves.

9. That the following precautions, emphasized by Dr. Atthill previous and subsequent to the operation, should be attended to : (*a*) The administration of a mild aperient before the operation ; (*b*) withholding solid food for 24 hours previous to the operation —allowing, however, beef tea, eggs, milk, and subsequent to it ice, milk and soda-water, beef tea ; (*c*) stimulants only to be

given in cases of collapse, or in those of exceptional debility; (*d*) opium, either by the mouth or hypodermically, should be given after the operation. The surgeon must exercise his own discretion as to the amount.

10. That pure ether is the anæsthetic that in most cases will be found to answer best.

Placental Origin of Congenital Heart Disease.—Dr. Von Hoffman records a case of congenital closure of the semilunar valve. The child suffered at birth from cyanosis, atelectasis, and great irregularity of the heart's action, and died from suffocation on the third day. The placenta had been previously examined and was found to be the seat of numerous recent and old extravasations. From these hemorrhagic foci pathological products had been introduced through villous absorption into the fœtal circulation, and had thus given rise to endocarditis. The placental extravasations had been caused by violent fits of coughing, from which the mother had suffered about the sixth month of pregnancy, which date also corresponds to the beginning of the fœtal endocarditis. Von Hoffman advises the careful examination of the placenta in every case of childbirth, and believes that much light might thereby be thrown upon the etiology of diseases of the new-born.—*Transactions of the German Medical Congress*, 1882.

Local Treatment of Erysipelas. — Dr. Rothe recommends the application of the following liquid every two hours to the affected parts:—

℞ Acid carbolic,
Alcohol, āā 1 part.
Ol. Terebinthinæ, 2 "
Tr. Iodinii, - - 1 "
Glycerinæ, - - 5 " M.

This mixture causes no pain. Internally, he recommends quinine and digitalis, and an emetic if indicated.

CANADA

Medical and Surgical Journal.

MONTREAL, FEBRUARY, 1883.

GRAND TRUNK SCHEDULE OF SURGICAL CHARGES.

We are in receipt of several letters from surgeons along the line of the Grand Trunk Railway, complaining that the tariff, which has been drawn up by the Medical Referee of the Company for their guidance, is, in the language of one of the correspondents, "absurdly low." The schedule, which we have been requested to publish, speaks for itself. It puzzles us to know how men with their eyes open can be induced to sign such a tariff, with the understanding that they are to adhere to it. They must either be ignorant of the work before them, or their surgery must be very much of the "trust to luck" variety. To take one item from the schedule—imagine a man performing Syme's amputation, and giving it the after-attention which such an operation demands—all for twenty dollars. Some one has got to suffer, but what odds, says the medical referee, so long as the interests of the Company are secured. We sympathize very much with those surgeons who feel that they cannot conscientiously sign such a tariff, and whose accounts are in consequence subjected to mutilation often beyond all reason.

G. T. R. SCHEDULE OF SURGICAL CHARGES.

Day visit	$1.00
Night visit	2.00
Office consultation	50
Dressing hand or foot first time during day	1.00
" " " " night	2.00
Subsequent dressings	50

The amount placed after the following accidents includes after treatment and medicines:

Amputation of finger	$ 5.00
" " metacapal bones	10.00
" " forearm	20.00
" " arm	20.00
" " toes	5.00
" Heys' Chopart's and Syme's	20.00
" " leg	25.00
" " thigh	50.00
Setting fractures:	
Forearm	10.00
Arm	15.00
Clavicle	8.00
Leg	25.00
Thigh	30.00
Reducing dislocations:	
Elbow	10.00
Shoulder	8.00
Ankle	8.00
Knee	10.00
Thigh	20.00

THE ETIOLOGY OF NEW GROWTHS.

Cohnheim's theory of the origin of tumors, propounded in 1877,* has brought out several elaborate investigations. He holds that there are, in the development of the embryo, certain residual cells not used, and which, under favorable circumstances later on in life, may multiply enormously and form tumors. Facts which appear to support this theory have been adduced by several writers who have transplanted portions of embryonal tissue into adult animals and studied the changes. Lwoff, working at the University of Kasan, has recently recorded the results of eighty experiments on this point. He found that bits of embryonic cartilage and periosteum of the rabbit, transplanted to the anterior chamber of the eye or to the jugular vein of an adult animal, grew and developed, forming true bone. After reaching a certain size, often ten times that of the original piece, the growth ceased, but the masses remained without undergoing

* *Vide* Canada Medical & Surgical Journal.

other changes for as long as ten months. In the case of bits transplanted to an animal of a different species, a slight proliferation of the cells took place, and the mass was then absorbed.

—We were beginning to think the days of "slashing" reviews had past, but there have been several of late which were quite up to the old standard. The maiden efforts of poor Fancourt Barnes were most cruelly received. The reviews of his translation of "Martin's Atlas of Gynecology," and of his "Dictionary of German Medical Terms," the former in the *Edinburgh Medical Journal* and the latter in the *American Journal Med. Science*, were 'stingers.' For a thorough, old-fashioned *exposé* of chemical, pathological and clinical ignorance of the worst kind, we have not seen anything so good as the review of "Harley on the Liver" in the January number of the *Dublin Journal of Medical Science*. In the concluding paragraphs are such sentences: "We have travelled from Dan to Beersheba, and found nothing but barrenness"; "We have read the twelve hundred pages, and found not one which we can commend to our readers." Unfortunately for the author, the reviewer's points seem all well taken, and his conclusions justifiable.

—New Medical Journals are not uncommon in Germany, but the latest—*Fortschritte der Medicin*, edited by the well-known pathologist, Dr. Friedländer of Berlin—has many good points. The arrangement is somewhat similar to the *London Medical Record*, and we can recommend it to our German reading subscribers as a journal in which good summaries of continental literature will be found. It is published by Theodor Fischer, Dorotheen Strasse, Berlin, bi-monthly; price 20 marks.

—The enterprise of the profession in Toronto is well known, but the *Canadian Practitioner* calls attention to a new development which, under the pleasing title of "The Integrity Medical Aid Fund," is likely to cast all previous efforts in the shade. It is a sort of Co-operative Medico-Chirurgical, Obstetrical, Gynæcological, Pædiatrical Supply Association, consisting of eleven doctors, who, for the sum of 30 cents a months, agree to

attend and provide medicines to any one who becomes a member of the Society. We are quite anxious to see a prospectus containing the names of the directors of this new enterprise.

— In the *Med. News* of Jan. 20th and 27th, Dr. T. M. Sternberg adduces evidence to show that the micrococcus of gonorrhœal pus is not the infective agent of the disease. His conclusions appear based on reliable data. He was able to cultivate it, but failed to produce the disease by introducing the culture fluids into the urethræ of healthy men. The organism appears to be identical with *Micrococcus ureæ*, which produces the alkaline fermentation of urine.

—We see it mentioned in an editorial in the *Lancet* of Jan. 27th, dealing chiefly with medical education in the United States, that the Trinity Medical School, Toronto, has a session of four years and a half. This statement is, we believe, erroneous, and is derived from the report of the Illinois State Board of Health. The only British or Colonial school requiring more than a four years' course is that of Melbourne, Australia, which demands five.

—In an obituary notice of Prof. Friedrich, Virchow states that of all the men who, during over thirty years, had acted as his assistants, only one previous to Dr. Friedrich, Dr. Hoffmann of Basel, had died. In the same number of Virchow's Archiv appears Friedrich's last communication, in which he strongly advises cauterization of the clitoris in certain cases of hysteria.

—Drs. Ringer and Murrell call attention in the *Lancet* (Jan. 6th) to the uses of manganese in various forms of amenorrhœa, given as permanganate of potash, in pill form, beginning with a grain three times a day, and increasing to two grains four times a day. They claim to have had striking results from the drug.

—We regret to see recorded the death of Professor Beneke of Marburg, well known for his researches on Nutrition. His late works on the Physiological Anatomy dealing with the size and proportion of the organs at different ages have been very important.

Obituary.

THE LATE JOSHUA CHAMBERLIN, M.D.

We have to record the death of Joshua Chamberlin, M.D., late of Frelighsburg, County of Missisquoi, a gentleman who has during the past fifty-six years deservedly occupied the most prominent position as a surgeon of eminence in that section of the country. He was born at Richmond, Vermont, on the 1st September, 1799, and thus completed his 83rd year, last September. When very young (in the year 1810) he came to Canada on a visit to his brother-in-law, the late Dr. John B. Chamberlin, who at that early date, was a practising physician at L'Assomption. During his visit he was attacked by smallpox, and after recovery he remained with his relative, and engaged in a preliminary course of study with the view of entering the profession of medicine. Dr. John B. Chamberlin removed West, and young Joshua followed his fortunes and acted as his assistant at Chatham up to the year 1823, when he came east and joined his brother, the late Dr. Brown Chamberlin, who at that time was a practising physician at Dunham. Dr. Brown Chamberlin subsequently removed to Frelighsburg, where he died in 1829. The subject of our notice, ever anxious to acquire a thorough knowledge of his profession, visited Montreal and entered as a student at the medical institution, which was at that time the only medical school in the country. This was about the year 1825 or '26. He attended two winter courses of lectures, and on May 10th, 1827, he passed his examination before the Medical Board of the Province, and obtained his license to practice. After the death of his brother, Brown Chamberlin, in 1829, he continued to practice his profession at Frelighsburg, where he resided up to the time of his death, which occurred on the morning of the 14th of January ult.

Living on the frontier, and much isolated, he was constantly thrown on his own resources, and acquired a reputation specially as a surgeon. His judgment was mature and his experience very large; he was an acute observer and a man of great strength of character. He enjoyed the confidence and friend-

ship of his *confreres* in the neighborhood of his home both in Canada and in the contiguous State of Vermont. In the early days, before railroads were in existence in that section of the country, it was no uncommon thing for him to ride 4 or 50 miles, through what was almost a wilderness, to visit a patient, or give aid to relieve the sufferings of his fellow man. He was possessed of inexhaustible energy, both physical and mental, and although staid and dignified, he was full of merriment, always ready to promote innocent amusement. No child enjoyed fun more freely, and he was ever ready to contribute to the many sports of the little ones. At the bedside, without levity, his pleasant voice and passing joke were often as good tonics as any to be found in the Pharmacopœia. In the year 1853 the Woodstock Medical College conferred on him the honorary degree of Doctor of Medicine.

During the political troubles of 1837 and 1838 he took his place as a staunch Conservative and supporter of British connection. He was a member and office bearer of the "Constitutional Association," and attached to the Militia of the County of Missisquoi. He acted as a combatant officer at the combat at Moore's Corners, and after the fight he attended assiduously to the wounded, among whom there was Mr. R. S. M. Bouchette, one of the leaders of the insurgents, who was severely wounded during the engagement, and who in after years spoke gratefully of the care and attention of the doctor. He was Associate Coroner for the district, and also for many years in the Commission of the Peace. From 1854 to 1858 he was named by the Government as a Commissioner to settle the disputes which had arisen respecting the rights of settlers upon old lands in Bolton, as against non-resident proprietors, and his report led to a satisfactory adjustment of the claims. Again, in 1866, after the Fenian raid of that year, we find him named by the Government as a Commissioner to adjust the claims of those who had suffered by pillage from the marauders. But while he labored outside of medicine, to render his life a useful one, he by no means neglected the interests of his profession. In 1849 we find him elected as one of the Governors of the

College of Physicians and Surgeons of Lower Canada to represent the District of Montreal, this being the first Board constituted under the act of incorporation passed in the year 1847. From this time he continued as a member of the Board of Governors, receiving the unanimous support of the profession as one of its representatives, and in July, 1865, he was chosen President of the College. Dr. Chamberlin continued to serve as one of the Governors after he had filled his term of presidency up to the triennial meeting in 1880, when he requested to be allowed to retire, as his advancing years and failing strength intimated the necessity for relinquishing active work. He died as he had lived, full of years, full of honors, and full of activity. The immediate cause of the fatal attack (Capillary Bronchitis), was brought on by exposure in going to see a person in the vicinity of his residence. He was carried to his grave by the loving hands of six of the members of the profession in the vicinity, and all those professional friends who could attend his funeral, did so to show a last mark of respect to the memory of the Nestor of Medicine.

In 1848 Dr. Chamberlin married Miss Westover, a sister of A. Westover, Esq., who led the farmers of the vicinity in the affair against the Fenians in 1870, the local militia being under the command of his nephew, Col. Chamberlin, of Ottawa. They had but one child, a daughter, who, with her mother, survives the doctor.

Personal.

Robert Logan, M.D. (McGill, '80), has passed the examination for the M.R.C.S., Eng.

We regret exceedingly to hear of the illness of our friend, Dr. John H. Stevenson of London, Ont.

James A. Grant B.A. (Queen's), M.D. (McGill, '82), son of Dr. Grant of Ottawa, has passed the L.R.C.P., Lond.

Assistant Professor Schäfer succeeds Dr. Burdon Sanderson in the Physiology Chair at University College.

Professor Helmholtz of Berlin, the celebrated physiologist and physicist, has been created a noble by the Emperor of Germany.

Louis Robitaille, M.D. (McGill, '60), brother of Dr. Robitaille, Lieutenant-Governor of Quebec, has been appointed a Dominion Senator.

By the death of Dr. Beard of New York, a prominent and widely known specialist has been removed. He was regarded by many as extreme in his views, but was a brilliant writer and investigator.

The Carnival brought many of our professional brethren to town. We were glad to meet Drs. H. P. Bowditch and J. J. Putnam of Boston, Dr. Carleton of Norwich, Conn., Dr. A. A. McDonald of Toronto, Dr. Derby of Rockland, Ont., Dr. Farley of Belleville, Dr. McDonald of Sutton, Que., and several others.

Medical Items.

—"Can it be *true*," said a lady friend to Miss ——, one of the Kingston lady students, "that you have actually dissected a *man?*" "Oh, yes," was the reply, "but it was an *old* man."

The Vacation of a Successful Practitioner.—Wife (to a doctor just home from a week's hunting): "Well, James, did you shoot anything?" Doctor (sadly): "No; awfully bad luck; never killed a thing." Wife (who knows him, sweetly): "My dear, you would have done better if you had stayed at home."—*Medical Record.*

The Dangers of a Large and Lucrative Practice.—We make the following extract from the *Evening Post*, which illustrates in a peculiar way one of the dangers of an extensive practice. It will be observed that the action of the court is not less extraordinary than the circumstances leading to domestic infelicity:—An Indiana court has just rendered a decision in a most extraordinary divorce case. The parties were Dr. Mather and his wife, living in the southern part of the State. Dr. Mather is a young, talented, industrious, popular, and prosperous physician. He married a lovely young woman and lived in fine style. His practice was constantly upon the increase, and he was frequently called up at night. The fact did not disturb him, as he

considered it his duty to respond at any time. His wife objected, however, though he frequently got away without awakening her. Finally he had a telephone placed in the house, so as to be able to consult at long range, and avoid going out except in the most urgent cases. He took every precaution to prevent any nervous strain upon his wife. She would not be satisfied. She demanded that he give up his night-practice, even if he lost part of his income. She urged her wealth could supply what might be lacking. To this the doctor made a very emphatic, though kindly denial. She persisted, and applied for a divorce. The husband, although deeply grieved at his wife's resolve, interposed no opposition, merely stipulating that as a matter of justice, to put the exact facts on record and beyond dispute, the trial should take place in open court. This suggestion was carried out, and it is from the sworn testimony the above outline is made. The suit itself was scarcely more singular than the remarks of the presiding judge. He said there could be no doubt, under the laws of Indiana, that Mrs. Mather was entitled to a divorce. He then proceeded to show how the progress of society had necessitated changes in the marriage laws. Indiana, he said, was a progressive State, and the people would never endure laws like those of other States, where couples like this must go on to the end of their days in unhappiness. He regarded this case as an excellent illustration of the beauties of Indiana law. The parties could now seek happiness where it might be found. —*Louisville Med. News.*

—The *New York Medical Record* is responsible for the following description of the sea-side sanitary hotel of the future :— Anxious guest to hall-boy : " Boy, where are the water-closets ?" " Haven't got any, sir ; they breeds fever. Boat goes down the harbor every morning—ladies at nine, gentlemen at ten." " Well, is dinner ready ?" " No, sir ; we always carbolize the dining-room before meals. Now they are spraying the waiters, sir." (Impatiently), " Well, where is your iced water ?" " Don't have drinking-water now, sir ; 'taint healthy. Yonder's our Labarraque mixture, flavored to taste. Have a glass, sir ?" Guest retires and takes a thymolized julep.

CANADA

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NOTHNAGEL'S KLINIK.

(From our Special Correspondent.)

VIENNA, Jan. 25, 1883.

The latest addition to the teaching staff of the General Hospital in this city is Nothnagel. He was formerly director of the medical klinik in Jena, a town containing not over 10,000 inhabitants. He is considered by those who claim to know all about such matters, the most distinguished clinical teacher of the many eminent German physicians of the present day. He is a hard, thorough, and honest worker. For a number of years he has occupied a high position as a scientific writer, not alone in Germany, but wherever medicine as a science is studied. He has written several of the articles in Ziemssen's Cyclopædia. Three years ago appeared his most important work, "The Topical Diagnosis of Diseases of the Brain." Such a work could only be written by a very learned and accomplished physician and physiologist. He has also written, in conjunction with Rossbach, the best work in the German language on Pharmacology and Therapeutics. He is no sceptic as to the value of drugs, and loses no opportunity of impressing upon his hearers the vast importance of an accurate and sound knowledge of the actions and uses of drugs. The physicians of the Vienna school have of late years prided themselves on their scepticism. This is in a great measure owing to the teaching and example of the late Professor Skoda. It is a good illustration of the evils of *authority*, and the harm that great men sometimes do. I heard

a prominent physician saying a few days ago that Skoda's influence was so great that it has very considerably retarded the progress of scientific medicine in Vienna during the last ten years. His successors were satisfied if they could even follow in his footsteps ; they did not dream of making footsteps of their own in the great untrodden ground. Now, however, Vienna has in Nothnagel a physician who will, if I mistake not, leave a deeper and better influence on the coming men.

The klinik, which is held in the amphitheatre in connection with his own wards, commences at 8 A.M. and lasts two hours ; during this time, one and sometimes two cases are investigated. The method of examination is as follows : After the patient's complaints are ascertained, and a general survey of the external surface of the body is made, the history of the present trouble, together with the previous and family history, are read aloud. Then the examination of the different systems and organs begins, and this is done in such a thorough manner that leaves nothing to be desired. After making a diagnosis (if this is possible), the treatment of the case is considered. A series of cases belonging to the same system are taken up in succession. This order is only interfered with when an acute case is received into the wards, the examination of which is able to teach some useful lesson. During the past week the following cases were examined :—Lead Palsy (extensors of the hand) ; Chronic Simple (?) Basal Meningitis in a man aged 35 ; Subacute Basal Meningitis in a girl aged 15, arising from an injury of the third cervical vertebra ; Tetanus, following a slight wound of the forehead, in a woman aged 30 ; Chorea of five years' duration in a girl aged 10 ; Syphilitic Basal Meningitis in a man aged 30 ; Hemiparesis, from Syphilitic Endarteritis, in a man aged 40 ; from a similar cause, Hemiparesis with Hemianæsthesia, in a man aged 30 ; Tabes Spastica (syphilitic ?) in a man aged 35. During the present week, a series of cases of diseases of the chest, exclusive of tuberculosis, are being considered. He devoted ten days to different cases of tuberculosis some weeks ago. When any of the cases that have been publicly examined prove fatal, all the class are present at the *post mortem*, which is performed by Kundrat, the professor of pathological anatomy.

This morning there was a *post mortem* performed on the body of a woman aged 65, whose disease was diagnosed as pernicious anæmia during life. Although no cause could be found to account for the anæmia, Nothnagel was suspicious that it might be a case of cancer of the stomach running its course without any direct proof of its presence. His suspicions were probably rather aroused by the fact that recently some physicians in connection with the hospital had been surprised to find at the *post-mortem* of a case, diagnosed by them as idiopathic anæmia, extensive malignant disease of the stomach, than by any evidence of the existence of such disease. The only changes found were extensive hemorrhages into the retina and fatty degeneration of the heart. The medullary cavities of several of the long bones looked normal to the naked eye. The liver was atrophied, but not fatty.

Recently, Nothnagel, in connection with a case of chronic obstruction of the bowels in a young man, gave his hearers a detailed account of some valuable experiments he performed during the summer months on the intestinal movements. Before referring to these investigations, I will give an account of the case. The patient, aged 23, complained of frequent nausea, pain in the belly and vomiting. He was much emaciated, and very anæmic. His present troubles commenced about four months ago, with pain in the abdomen and vomiting. The pulse varies between 30 and 50; temperature under the normal. The tongue is red and dry. There is great thirst and loss of appetite. He vomits three or four times daily, and generally from two to three hours after eating. The vomited matters are colorless, slightly acid, and distinctly fæculent. There is obstinate constipation. The injection per rectum of a 10 per cent. solution of common salt brings away fluid exactly resembling the vomited matters, and which is found, on microscopic examination, to contain muscle fibres colored by the bile pigment, fatty needles, and starch. From the presence of the latter it was concluded that the intestinal digestion was faulty. In speaking of the clay-colored stools, it was remarked that they may appear in disease of the liver and intestines, where there is not a trace

of icterus. Bamberger, thirty years ago, pointed out that colorless stools are found in obstruction of the bowels without the presence of jaundice. The abdomen is *retracted*, and every few minutes distinct peristaltic waves can be seen, from even a distance of 20 feet, passing from the epigastrium downwards to the pubes, and confined to the middle of the abdomen. During these movements the patient complains of nausea. The urine was found to contain a large quantity of indican. In all the cases of abdominal diseases examined during the present session indican was found in increased quantity in the urine. The best test for its presence is to add to a small quantity of urine in a test tube, an equal amount of hydrochloric acid and from one to three drops of a concentrated solution of chlorate of potash. If indican is present in an increased quantity, the mixture becomes blue, and, after a few minutes, if the quantity is very large, black. The latter change, from blue to black, is said to only appear in obstruction of the bowels.

The diagnosis made in this case was obstruction of the bowels at the ileum. The reasons given for placing the seat of the obstruction in the small intestines was that the ascending colon was not dilated, and that it was free from peristaltic waves. On account of the extreme and progressive wasting, the obstruction was considered to be owing to a neoplasma, although no tumor, thickening or resistance could be felt anywhere. For the same reason the prognosis was unfavorable, and the treatment by surgical interference not feasible. The most important part of the palliative treatment was said to be to favor the passage of the bowels. Unless this was attended to, the over-active intestinal muscles would soon loose their power. The best means of preventing this paresis is to give daily injections of a 5 or 10 per cent. solution of common salt. This patient continued to grow gradually worse, and died ten days after the examination. For three days previous to his death, the matters vomited and the stools were of a dark-brown color. This change in color was owing to the presence of hæmoglobin. At the *post-mortem*, a sarcomatous tumor was found uniting the stomach with the splenic flexure of the colon. Its centre was broken down, thus making

a direct communication between the stomach and colon. The stomach was found to be healthy. The duodenum was dilated, but the ascending colon was normal in size. In commenting afterwards on the results of the *post-mortem* in this case, as regards the mistaken topical diagnosis, Nothnagel said that it was much more difficult to locate exactly diseased processes in the intestines than it was in the brain. He admitted that he could not explain how the ascending colon remained normal in size and free from peristaltic waves during life. He was of the opinion that the communication between the stomach and transverse colon took place about three days before death—at the time that the matters vomited and the stools became dark in color.

In speaking of his experimental studies, Nothnagel said his method of investigation was to keep chloroformed animals (dogs and rabbits), with their abdomens opened, immersed in a bath (100°F.) of a half per cent. solution of common salt. He has demonstrated by this method that, in animals at least, no peristaltic actions occur in uninjured intestines. The effect of injections into the rectum was examined, colored fluid being used. It was found that a small quantity of water had no effect on the peristalsis. A considerable quantity distended the rectum without exciting any action. Iced water caused action sufficient to move the fluid from 15 to 20 centimetres up the bowel. Olive oil had a similar action. A strong solution of common salt, forced up by a syringe a distance of 10 centimetres, was carried up, together with a mass of fæces, by the antiperistalsis to the cæcum. Similar results were obtained by using concentrated solutions of nitrate of potash and bromide of potassium. The common salt injections always caused contractions, which passed both ways. In a case of ileus in the human subject, an injection of colored salt solution, which was used during life, was found, after death, to have reached the cæcum. The conclusions to be derived from these experiments are that in intestines in a healthy condition, or containing only unirritating contents, peristalsis only occurs from above downwards, and if there are any irritating substances in the bowel, antiperistalsis occurs also. To explain the occurrence of fæcal vomiting in intestinal obstruction, ligature of the small

intestines was resorted to. It was found that unless irritating substances were introduced into the bowel, no ascending contractions occurred. When the intestine is ligatured, the part above becomes filled and the part below empty. Descending contractions are generally seen commencing at the stomach and terminating at the distended portion, and as the distension ascends higher and higher, the waves of descending contraction travel less and less, until finally they are limited to a narrow segment near the pylorus. There is no such thing noticed as antiperistalsis sufficient to bring about fæcal vomiting. Its true cause is due to the action of the diaphragm and abdominal muscles. The paralyzing effect of distension of the bowel above the ligature proves clearly the well known injurious effect induced by the use of purgatives in intestinal obstruction. By increasing the peristaltic contractions, they carry the contents of the intestines more rapidly and violently to the seat of obstruction, and in this way the paralysis which follows distension is more quickly brought about.

Nothnagel had many opportunities of noticing the occurrence of intussusception during the course of his experiments. The invagination always occurred from above downwards, a part that was contracting strongly slipping into a portion that was at rest. He was often able to remove these invaginations by injections of salt, which set up an antiperistaltic movement. Morphia, in doses of from one-sixth to two-thirds of a grain, has the power of preventing the antiperistalsis induced by salt injections, but if larger doses are given, from a grain and upwards, then, not not only does the antiperistalsis appear, but in an aggravated degree. This anomalous effect Nothnagel ascribes to the small doses stimulating and the large one paralyzing an inhibitory mechanism which is antagonistic to the nervous mechanism stimulated by a salt solution. This action is comparable to that of digitalis on the innervation of the heart: small doses stimulating and large ones paralyzing the inhibitory fibres of the vagus. The constipation produced by morphia is thought to be owing to a stimulation of a nervous mechanism which other experiments have located in the splanchnic nerves.

Tetany.—During the last few weeks there has been an epidemic of this strange disease in this city. Up to the present I have not heard of any fatal results. It is mostly young people that are affected. The following case may be taken as an average sample of the present epidemic :—

A boy, aged 18, who, on his admission into hospital, complained of cramps in his fingers. The cramps came on suddenly two days before, and at that time he was feverish. On examination, it was found that there were tonic contractions of the fingers and thumbs of both hands. The points of the index and little fingers met in front of the other two fingers. Both hands were in a state of partial flexion. It required considerable force to overcome this contraction. The facial muscles were contracted in such a way as to produce what is known as the *risus sardonicus*. The muscles of the upper arms, lower extremities, trunk and neck were free from spasm, but their mechanical and electric irritability was much increased. This change was even more marked in the muscles affected with the cramps. Strong pressure on the brachial arteries increased the spasm.

Five days after this patient's admission, he was discharged as cured. He was warned, however, that the spasms might return, but as two days had passed in freedom from them, this was not considered probable. He was treated by the internal administration of bromide of potassium and the faradization of the contracted muscles.

As to the causes of this disease, little is known. The great majority of the cases in Vienna are seen during the months of January, February and March. The epidemic form is most common in boys about the age of puberty. It is not uncommon in women who are nursing. It is sometimes seen during the course of Bright's disease and cancer of the stomach. It has been seen accompanying the onset of one of the acute specific fevers. It is seen following the removal of enlarged thyroids, especially in girls. In severe cases, the muscles of both upper and lower extremities, together with those of the face and trunk, are the seat of spasms. The spasms are not always constant, but often intermittent. They last, as a rule, from one to twelve

hours, and the intervals of freedom from them from one hour to three days. The most remarkable symptom of the disease is the enormously increased electric excitability of the nerves, not alone of those which supply the muscles, the seat of the spasms, but of nearly all the peripheral nerves of the body. The only exception to this, and that is only occasional, is the facial. What is still more remarkable, is, that during the "latent period," when the patient, to all appearances, is quite well, this increased electrical reaction is present, and although not so prominent as during the cramp period of the disease, it is marked enough to be considered as absolutely diagnostic of the disease. So decided is this irritability, that in some cases, without causing the patient much uneasiness, a tetanus of the muscles can be produced by opening the kathode—the kathode-opening tetanus (*Ka O Te*). In a normal state of the nerves and muscles, the above reaction requires such a powerful current as to be very dangerous to life. Why the nerves of the extremities and trunk should always respond in the manner described, and the facial only sometimes, is not known. The increased excitability of the nerves to mechanical irritation, which was first pointed out by Dr. Weiss of this city, is always present, and it is especially marked in the facial. A slight pressure on the skin over the part where the facial divides into its terminal branches in the case reported was sufficient to set the muscles supplied by this nerve into contraction. Very few cases of the epidemic form of the disease prove fatal, but it is otherwise with those following the removal of enlarged thyroids. In Vienna there have been five deaths from tetany due to this cause. Since the introduction of antiseptic surgery has banished septicæmia in these cases, tetany leads the list as the cause of death following these operations. It is often very chronic. In one case it lasted, with intervals, for eighteen months, and eventually proved fatal. I believe that all the very chronic cases are those that follow Goitre removals.

As to the nature of the disease, nothing definite is known. Weiss, taking, as a starting point, its frequency after thyroid operations and its intermittency, throws out the suggestion that it may be owing to irritation of the sympathetic nerves, by means

of which alternate waves of dilatation and contraction are carried to the spinal grey matter. Billroth appears to be satisfied that it cannot be owing to any interference with the recurrent laryngeal, as he, in all his operations, has been particularly careful to preserve this nerve from irritation. In the treatment of the idiopathic form, the stabile galvanic current, or the interrupted current, can be used. There is, however, nothing definite, as yet known, as to the value of either form of electricity in this disease. In all cases that I have seen, bromide of potassium was given in large doses. In those cases following the removal of enlarged thyroids, Billroth recommends the application of an ice bladder to the nape of the neck.

TONSILLOTOMY AND UVULOTOMY.

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[*Read before the Medico-Chirurgical Society of Montreal.*]

Both of these operations the general practitioner is occasionally called upon to perform, and both might be undertaken with advantage oftener, as I shall endeavor to show in this paper.

There is an ill-defined, but influential misgiving on the part of patients as to having either the tonsils or the uvula lessened by any sort of cutting procedure; most persons supposing, when operation is proposed, that the entire removal of the parts is intended. Not infrequently the question is asked, Why remove parts that surely were intended to fulfil some function? The question is not an unnatural one, and the patient is entitled to an answer, and a clear one, too. When should a portion of the tonsils be removed? It must be borne in mind that the tonsil in the adult, as it lies between the pillars of the fauces, is scarcely visible, and it may be considered more or less enlarged if it project beyond their edges. It must further be remembered, that in swallowing, speaking and singing, especially in the higher register, the pillars of the fauces on each side approximate very considerably. It is plain that tonsils so much impede, or are in the way of those actions in proportion to the amount of enlarge-

ment. Tonsils, therefore, that may be left alone in one person, may be advantageously removed in another, if the latter be a public speaker or singer. A pair of hypertrophied tonsils must hinder a singer or speaker, as weights or such like impediments would an ordinary laborer. Sometimes persons assert that the enlarged tonsils do not hinder them in the discharge of the functions that belong to the throat, yet, after removal, declare they experience a sense of freedom formerly unknown to them. I have had two such cases of late in persons accustomed to sing. It is very much to be questioned whether a singer can do himself justice with a pair of tonsils at all seriously enlarged ; certainly there must be much greater effort to attain the same result, which would tell upon the powers if much vocal work were to be undertaken.

No doubt enlarged tonsils contribute greatly to increase, if not to cause, pharyngeal irritation. According to my own observation, they keep back secretions which otherwise would be removed ; and in cases of naso-pharyngeal catarrh, I have noticed special accumulations of discharge on that side on which there was enlargement of the tonsil. These are a few aspects of the subject not usually presented in the books. There are others so obvious that they have arrested the attention of all observers such as oral respiration, snoring, altered visage, occasional deafness, &c. But a condition occurring in an infant of three years that was brought under my notice by an officer of this Society was so remarkable that an account of it may illustrate the subject of this paper better than a lengthened general description. A child of three years of age, that had for some time shown some evidences of throat obstruction, within a few weeks passed into an acute condition that was positively dangerous. The little one had more or less noisy breathing, kept the mouth constantly open, had grown pale and feeble, and, within the two weeks previous, had several choking fits when attempting to swallow food or drink. At night she was two or three times so nearly suffocated that she seemed afraid to go to sleep, and when she did rest, her sleep was evidently disturbed by dreams. Examination showed a pair of tonsils so enlarged, they almost met in the

middle line. Both were removed by Mackenzie's Tonsillotome at one sitting, the operation occupying not more than one minute. All the symptoms disappeared at once.

Should tonsils be removed when acutely inflamed? On this subject there is some diversity of opinion. As a rule, in my own opinion, they should not; but to this there is one exception. When tonsils have become somewhat, though not much, enlarged, and are subject to repeated attacks of follicular inflammation, their glandular structure is largely, if not wholly, destroyed; they are foreign bodies, and nothing can restore the functions of the superficial parts—at least, I see no reason why a portion of such tonsils should not be removed, for, on the slightest provocation, they take on inflammation. But until they are inflamed, they do not protrude sufficiently beyond the edges of the pillars of the fauces to allow of a neat and otherwise satisfactory operation. Operating during the acute attack seems justifiable and desirable in such cases.

How should the operation of Tonsillotomy be performed? Not with a bistoury, unless in the most exceptional cases. The dangers that belong to the operation are *the dangers of the bistoury*. There is an amount of dread on the part of the patient, and of anxiety on the part of the practitioner, which a suitable instrument reduces to a minimum. The instrument which to me seems vastly superior to all others is Mackenzie's Tonsillotome. It offers so many advantages that it seems to be almost perfect. It is strong; it can be kept sharp; it is easy to place in position; by it the amount to be excised can be definitely regulated by a practiced hand; it is swift of action; it acts as a gag to keep the mouth open; and it is free from the risk of causing serious hemorrhage, at least by opening the carotid. Velpeau reports four fatal cases from opening the carotid, but in all these the knife was used; and it has been asserted that it would be impossible to cut the carotid with Mackenzie's instrument. There are different sizes of the tonsillotome; but two, a very small one for children and a large one, will answer almost every purpose. Another advantage, and an important one, that may be claimed for this instrument is, that it cuts away the whole zone of tonsil

operated on, and does not leave a portion at the lower part to cause irritation, as other instruments are likely to do. The class of instrument represented by Fahnestock's seems to me too light.

In operating, in the case of children, some assistant, not necessarily a trained one, may help by pressing over the tonsils from without. In the case of the adult, he may do this for himself. When the tonsils are of the pale, tough, fibrous kind, a good deal of force in pushing home the cutting blade may be requisite, and a naturally strong hand is an advantage ; but it is in just such cases the superiority of the instrument is shown most, for its weight, strength, and the other qualities it possesses all come into play. Usually there is not much hemorrhage. Occasionally the tonsil has become *adherent to the pillars*, and then as vessels may be cut in their length, there may be a little more blood lost. Should the bleeding continue, pieces of ice may be sucked, or ice-cold water held in the mouth. If these fail, then a strong solution of tannic acid may be tried, or, better still, pressure with cotton wool either simply moistened with cold water or with a solution of tannic acid. It is customary at the Golden Square Throat Hospital in London to give each patient, before he leaves the operating room, a saturated solution of tannic and gallic acid, to be sipped slowly if required by after hemorrhage. I never witnessed a case of severe hemorrhage from tonsillotomy at that hospital. The bistoury was never used in any of the numerous cases that came under my observation.

The function of the uvula is chiefly two-fold. First, to complete the soft palate as a curtain, which is to close perfectly the posterior nares ; secondly, to prevent, in speech, involuntary vibration of the soft palate, which must necessarily interfere with good utterance. It follows that the uvula should never be cut away *close*. The amount to be removed may be regulated in each case by the rule : *To leave as much as would be there if the parts were natural.* This must depend on the size and general configuration of neighboring parts. When properly done, it is an operation causing so little actual pain, that it may often be desirable to perform it to facilitate further treatment of the throat or nose. An elongated uvula may be seriously in the

way of the use of a post-nasal douche or atomizer. For this operation, no instrument that has been devised seems to me to suit half so well as a *pair of forceps to hold the tip and a pair of scissors to snip off the excess*. My own method is briefly as follows: Placing the light (I use artificial light and the head mirror for all throat work) at such a height that my own hand will not obscure the view when operating. I seize the uvula by the tip with a long pair of forceps; having determined what proportion of the whole to remove, I then stretch the uvula to some extent, direct the scissors so as to cut squarely across, but somewhat upwards. The results are: less bleeding, because less tissue is cut through, and a pointed stump so like the natural in the most successful cases that the best trained eye could not decide that an operation had been performed at all. Unless the hemorrhage demands it, it is better to use nothing to arrest it, for all sorts of hæmostatics, even cold water, increase the soreness that sometimes follows this operation.

REPORT ON THE BRAINS OF RICHARDS AND O'ROURKE.

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(*Read before the Medico-Chirurgical Society of Montreal.*)

Although Benedikt's conclusions have been shown to be unwarranted, and we shall probably never be able, in a given collection of cerebra to pick out those which have belonged to criminals, still, a certain interest and value is attached to the examination of the brains of individuals who have rendered themselves notorious by the commission of great crimes.

I.—Richards, aged 52, a large, powerfully-built man, murdered a comrade in the Eastern Townships last summer. He was tried at Sweetsburg and condemned to be executed, but the evening before the appointed day he cut his throat with a small pen-knife. He appears to have been a thorough-going criminal, "smacking of every sin that has a name." Dr. H. LeRoy Fuller of Sweetsburg kindly sent the brain for examination, and furnished the following brief report of Richards:—"According

to his own statement, he has been a thief, a robber and a liar since ten years of age. A portion of his life was spent in the army, from which he had deserted, and bore the brand on the left side; was taken back and afterwards discharged as unfit from a moral point of view. About fourteen years of his life were spent in prison, and in addition to hard drinking, he was, according to his own account, much given to women. He may have had syphilis, though there were no external signs of it, nor had he any manifestation during the eight months that he was under my observation. While here he has been healthy, with the exception of an attack of diarrhœa and occasional frontal headaches. He had a scar at or near a point corresponding externally with the small spot of softening found on the frontal lobe. This, he said, was caused by the thrust of a bayonet."

Brain.— Organ weighed 47 ozs.; was well formed; hemispheres cover the cerebellum. Membranes and substance very anæmic. Membranes were normal: arachnoid a little opaque over the sulci. Vessels empty.

Fissures.—In right hemisphere, neither the fissure of Sylvius nor the fissure of Rolando joined contiguous ones, though a shallow groove connected the precentral with the latter. Both the retro- and pre-central were well marked; the latter was longer than the fissure of Rolando, and passed deep into the operculum. A short sulcus passing from the precentral fissure, split the hinder end of the superior frontal gyrus for 3 cm. The sup. frontal fissure was separted by a narrow bridge from the precentral fissure, and, anteriorly, sent three or four secondary sulci into the superior and middle gyri. The inferior frontal fissure was well marked, and had many secondary sulci. The interparietal fissure arose from the middle of the retro-central, and sent numerous secondary sulci into superior parietal lobule and angular convolution, joined the horizontal occipital, passed around the angular and united with the first temporal sulcus. Wernicke's fissure was marked. The temporal fissures were normal. On the median surface, the fissure of the corpus callosum passed deep into and had many secondary sulci in the precuneus; parieto-occipital and calcarine fissures were normal. On the left hemis

phere, the fissures of Rolando and Sylvius did not join contiguous ones. The superior and inferior frontal ran out from the pre-central, and were exceedingly well defined. The retro-central was separated by a very narrow bridge from the fissure of Sylvius, and had three deep branches in the superior parietal lobule, and a deep and wide fissure in the hinder part of parietal lobe, which joined the horizontal occipital. The fissure of the corpus callosum was interrupted about the middle of its course by a convolution uniting the gyrus fornicatus and the first frontal. The parieto-occipital and calcarine fissures were very deep, and ran to the sassura. Calcarine was normal. Wernicke's fissure was not marked.

Convolutions.—On the right hemisphere, the frontal gyri were well developed, the ascending was wide and large. The superior was split in its hinder part. The middle and inferior presented nothing special. The orbital gyri were normal. The ascending parietal was narrow. The other parietal and the occipital gyri presented nothing noteworthy. The gyrus fornicatus was narrow. There were five gyri in the insula. On the left hemisphere the ascending frontal was large; the superior, middle and inferior well defined, the first not divided; the middle ran out from the ascending, interrupting the pre-frontal fissure. In the parietal lobe, the ascending was isolated and well defined. The supra-marginal was large; the angular was much fissured. The first and second temporal gyri were divided by fissures, and there was a junction of the two by a narrow bridge. The gyrus fornicatus was split; precuneus well marked. There were five gyri in the insula. On the anterior angle of the third left frontal gyrus, just where it joins the orbital gyri, there was a superficial patch of softening, 1 by 1 cm., apparently hemorrhagic, involving the grey matter.

Summary.—The asymmetry between the convolutions and fissures of the hemispheres was very slight. The organ was not of the marked confluent fissure type. The secondary and cross sulci were not excessively developed. The majority of the convolutions were arranged in a normal and typical manner.

II.—O'Rourke, on the 20th of January, 1882, in the

county of Nelson, Ont., killed a farmer and his daughter, with whom he had quarrelled. He was an uneducated man, and had led an irregular life, going about as a day laborer. He had served two years in the Penitentiary for perjury. Dr. Freeman of Milton writes to me : " He had illusions, believed that he saw ghosts, particularly that of his mother and that of a late Dr. Ford. He was so timid that he required either a light in his room or somebody to sleep with him. The reading of murder trials to him was his greatest treat. He left the house of the Mahers in the morning with the most friendly feelings, went to an hotel and got three pints of whiskey ; returning to the house about nine o'clock in the evening, he had some words with Maher and his daughter, and murdered them both with an axe, and attempted to kill the son on his return. He told the neighbors that young Maher had killed his father and sister, but when arrested in the morning he confessed. He was indifferent before and after the trial, and said a person had only once to die. He never expressed any remorse." Insanity was pleaded in his defence.

Brain.—Received in good condition from Mr. Freeman, medical student. Hemispheres symmetrical ; they scarcely cover the cerebellum.

Frontal lobes.—Right side—The ascending branch of the Sylvian fissure passed up and formed a precentral fissure extending to within an inch of the longitudinal fissure, completely separating the 2nd and 3rd frontal gyri from the ascending frontal convolution. A short precentral fissure passed parallel to the upper half of the fissure of Rolando, and was then separated from the portion just described by the base of the second frontal gyrus. The first frontal fissure was well marked. A secondary fissure united it in the middle of its course with the lower prefrontal fissure, and divided the 2nd frontal gyrus into two portions. The second frontal fissure was well marked anteriorly. The first frontal gyrus was typical ; the second was split in its posterior part, and, anteriorly, the lower division unites with the first frontal gyrus. The third convolution was small. The orbital surface was small, and showed only four radiate fissures. On the *left side*, a deep precentral fissure extended

across the hemisphere without interruptions. The first frontal fissure was well marked in the middle region, but did not extend into the præcentral. The second frontal fissure had many secondary branches. The ascending frontal gyrus was large. The first was typical; the second was much fissured, and, anteriorly, was partially divided into two. The third was normal. Orbital fissures and gyri presented nothing notable.

Parietal lobes.—Right side—Fissure of Sylvius was partially confluent by a shallow groove with the first temporal, and by a deeper one with the retro-central. The ascending branch passed far up into the frontal lobe. The fissure of Rolando was not confluent. From a deeply placed, small convolution in the middle of the parietal lobe, five fissures radiated; three passed down, of which the anterior formed a short retro-central fissure, which joined the Sylvian; the middle joined the first temporal; the posterior had two branches, one could not be traced owing to injury of the brain by the saw, and the other passed up and joined a fissure in the situation of the posterior part of a normal interparietal fissure. This lobe was much and irregularly fissured, and the supra-marginal, angular and superior parietal convolutions were greatly intersected. The retro-central gyrus was well developed. *Left side.*—Sylvian fissure was not confluent; fissure of Rolando normal. The retro-central was marked, and the inter-parietal passed out from it at right angles and back into the occipital lobe, but did not join any of its fissures. It had several secondary branches, which passed into the angular gyrus. The retro-central convolution was not so well marked on this side. A small triangular convolution separated it from the supra-marginal.

Temporo-sphenoidal lobes —In the removal both had suffered, particularly the right. So far as could be traced, the first temporal fissure joined the inter-parietal and also the Sylvian by a narrow groove. The third temporal fissure was marked, and joined the calcarine. The first convolution was large. On the left side, neither the first nor the second fissures were marked anteriorly, but vertical sulci divided the convolutions. The hinder part of the lobe was broken. The third was well marked, and joined the inferior occipital and Wernicke's fissures.

Occipital lobes.—The saw had passed through the lateral part of the lobes. On the right side there was a small Wernicke's fissure, which united with the horizontal occipital and (so far as could be made out) with the second temporal. On the left side Wernicke's fissure was very marked; it joined the third temporal.

Median surface.—Left hemisphere—Calloso-marginal fissure normal. Parieto-occipital deep, and extended an inch on the convex surface. The calcarine also passed over the margin. The continuation of these two passed to the scissura hippocampi. The collateral joined the calcarine by a deep fissure. The convolutions were normal. The precuneus was deeply fissured. On the right hemisphere, the calloso-marginal fissure passed far back, and was separated from the parieto-occipital by a narrow convolution. In its anterior half it was double; one branch fissured the gyrus fornicatus in the front part. An ascending portion formed the anterior boundary of the præcuneus. Parieto-occipital was deep and marked, and curved over the margin. The calcarine was not so well defined. The united fissure ran to the scissura hippocampi, and also joined the collateral by a deep sulcus. The gyrus fornicatus was split into two portions. The precuneus and the cuneus were much fissured. The cerebellum, pons and medulla presented nothing of note.

Summary.—The two hemispheres presented a marked asymmetry in the convolutions and sulci. There was no special degree of confluence of the fissures, with the exception of those of the right parietal lobe. In both frontal lobes there was a partial splitting of the 2nd frontal convolutions, and an approach to the type of four frontal convolutions. The secondary sulci and furrows were unusually abundant.

QUARTERLY RETROSPECT OF SURGERY.

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Mr. Charles Roberts, F.R.C.S., in an article in *London Lancet*, Sept. 10th, 1882, on "*Some Deformities of the Body incident to the period of Girlhood*," remarks that Orthopœdic

Surgery as a speciality is a great evil both to the profession and the public. The specialist who concentrates all his attention on a narrow field of study and practice is tempted to exaggerate its importance, and to analyse and disintegrate his facts till he loses sight of their relation to and dependence on each other; while, on the other hand, the general practitioner is disheartened and repelled by the apparent complication of the subject, and is induced to hand over to the specialist many cases which he is quite competent to treat, or, as is often the case, to undervalue the importance or deny the existence of many deformities. The author says no deformity of a child's body gives rise to so much alarm to parents, or is the subject of greater diversity of treatment among medical men, as lateral curvature of the spine, and, this is due he believes to an imperfect acquaintance with its origin. Specialists are accustomed to treat lateral curvature, knock-knee, and flat-floot as distinct deformities, while in truth tney are all links in the chain of one deformity. Mr. Roberts thinks in all cases lateral curvature is due to the loss of lateral balance of the body in the upright position, and is an effort of nature to maintain the centre of gravity of the body and support the head and shoulders in the position which requires the least expenditure of muscular effort. The paralysis, wasting, or loss of a limb, or shortening of one of the legs by disease of a joint, rickets, knock-knee, or flat-foot in growing children will produce lateral curvature, and these are its chief if not its only causes. He does not think it a deformity owing to general debility or to awkward sitting position. The curvature thus produced is antero-posterior or round-shoulder. It is almost peculiar to girls verging on puberty, is found in the strong and healthy as well as in the weak and delicate. It is less common among the labouring classes than among the rich and well to do. He is satisfied, after a careful examination of the subject, that acquired lateral curvature in girls is due to the change of position of the lower limbs resulting from the development of the pelvis from the infantile to the female type a year or two before the accession of puberty. At puberty the knees in women are brought closer together, and the peculiarity in her gait in running is due to the fact that she has to move her knees round

each other and to throw the feet in a succession of small semi-circles. A little additional strain will convert this condition into knock-knee, and by throwing the weight on the inner ankle the arch of the foot is quickly broken down and flat-foot is produced. This deformity is exceedingly common among women, and a French *savant* has lately quoted it as a proof of the physical inferiority of woman to man. To a slight extent flat-foot may exist in all women, and Mr. Roberts suggests that it may be Nature's plan to promote what anthropologists call marriage by capture. To a large extent, however, flat-foot is the result of civilization, and he says that the highly arched in-step and the everted foot are peculiar to civilized peoples. Both conditions owe their existence to the wasting of the muscles which flex the toes and foot by the constant use of tight shoes. It is owing to this that Europeans have small ankles and large calves, of which they are so proud. High heels also assist in producing this deformity by removing the centre of gravity forwards. In treating deformities of the spine and legs incident to healthy girls, it is obvious, says Mr. Roberts, that attention must be directed, in the first instance, to correcting the deformed knees and feet. On the very first signs of the arch of the foot giving way, the girl should wear flat-soled well-fitting boots with India rubber or felt pads inside to support the arch, and special exercises favourable to the development of the flexor muscles should be undertaken. Support to the arch of the foot prevents knock-knee and lateral curvature. If knock-knee should come on, it can be corrected by the temporary application of long splints, especially in bed at nights. No apparatus is necessary for the curvature of the spine in its earlier stages, as it will disappear on restoring the lateral balance of the body. Much walking and standing should be avoided and short but vigorous gymnastic exercises substituted, and, when possible, the recumbent position assumed. Sitting on the ground or on a sofa in the cross-legged Oriental position serves to expand the pelvis, evert the knees and invert the ankles and counteract all deformities, while sitting on chairs with the legs crossed, directly favours them.

This very interesting article of Mr. Roberts is full of most useful ideas, and should be read carefully in the original by every practitioner interested in the health of the female sex—but, like all men with a hobby, Mr. Roberts rides it to death. That all cases of lateral curvature are due to flat-foot is rather a sweeping assertion, and, as far as my experience goes, not an exactly correct one. If flat-foot produces lateral curvature, and lateral curvature is more frequently seen in the well to do classes than in the labouring classes, how does it happen that flat-foot is so frequently seen in the labouring classes? In my experience it is more common in these, and this I hold is due to their often being compelled to carry weights about the age of puberty when the ligaments are relaxed, the system taxed by the momentous changes going on at that time, and the feet having to carry increased weight. How is it, again, we do not see lateral curvature in boys, yet flat-foot is not uncommon among them? Anatomists have always held that the large calf in European races is due to the less prominent os calcis requiring more leverage power and so more powerful muscles, and the slender calf in dark races is due to prolonged heel requiring the less leverage and not so powerful muscles—thus there is always a constant relation between the size of the calf of the leg and the length of the heel. The highly arched instep is not peculiar to civilized people. The North American Indian, as is well known, has a very high arched instep: although, as a rule, he does not go bare-foot, still the play of the muscles is not interfered with by the mocassin he wears to protect his feet.

On the Treatment of Glandular Inflammation.—It is now four years since Kapesser (an army surgeon in Darmstadt) described his method of treating glandular inflammation by the inunction of soft soap. One of the first observations he made was in the case of a badly nourished scrofulous little girl, whose neck was immensely swollen and discharged copiously fœtid pus from 6 to 8 fistulous openings, there was also corneal ulceration, and no improvement by previous treatment. Recollecting a case in which, by ordering inunction of soft soap for scabies, the phenomena of scrofula disappeared together with the scabies,

Kapesser adopted this method again with such success, that in four weeks the unsightly swellings nad been reduced to a few small easily movable glands about the neck, and the inflammation of the eye had subsided, leaving only slight haziness of the cornea. When the treatment was discontinued, the child returned to its bad condition, and when treatment was resumed improvement rapidly followed. Recently Kapesser has gone a step further, and treated phthisical patients with pleuritic exudations, hæmoptysis, night sweats, &c., in a similar manner, with the result of cessation of the pathological processes, increase of body weight and return of the capacity for work.

Beetz, who used this method in Von Ziemssen's clinic at Erlangen in 1873, can corroborate Kapesser's observations. In addition to scrofulous tumors, he has used it in the lymphadenitis of adults, and finally in every case of subcutaneous inflammation, using different preparations of soap as the case required. He says a whitlow, if not already too far advanced, yields very promptly to the influence of warm applications of spiritus saponis viridis (a solution of two ounces of soft soap in one ounce of alcohol). But one of the most satisfactory of affections to treat is bubo, and since Beetz has introduced his treatment, he has never found it necessary to treat buboes otherwise. For the last nine years his treatment has been as follows:—For chronic glandular indurations or abcesses in places in which it is difficult to apply dressings, he uses inunctions in the evening with green soap which is washed away the next morning, and repeated during three or four days with a subsequent interval of a day or more according to the sensitiveness of the skin. For acute glandular inflammations, whitlows, and abcesses in easily accessible positions, linen rags are steeped in spirits of green soap, applied to the part and covered with gutta percha tissue, these must be accurately applied by the surgeon, and not left for the patient to apply himself, there will be no tedious suppuration by this process; a very small abscess may form in a bubo thus treated, but there will be no trouble in walking. Hausmann and Kohlmanns speak even more strongly than Beetz. Kohlmanns reports cures of cases of

caries of the sternum and tarsal bones by the inunction of soap rubbed in twice a week in the evening. Soft soap cleans the skin by being split up into acid and basic salts by abundance of water. The excess of alkali in these salts combines with the fat of the skin, forming soaps which can be washed off by water. The caustic potash softens the skin and acts better when in the form of a fomentation, the tension of the surrounding parts is relaxed, blood-stasis does not go on to diapedesis of the white corpuscles. Sinitzins has shown that in addition to softening the skin, soft soap dilates the blood-vessels and thus checks the inflammation, the spot in which there is most pus has not the tension around it as before, and the pus can easily push through the softened corium (*London Med. Record*, Aug. 1882). Prof. Senator considers that amid the many new remedies introduced, some of the old have fallen undeservedly into disuse, among these especially soft soap (*Berl. Klin. Woch.*, No. 38, 1882). He has used inunction of soft soap in numerous cases with most distinct benefit, viz., in chronic non-scrofulous glandular swellings, indolent syphilitic glandular swellings, and in serous exudations, including the exudations in synovial cavities. He cannot come to a definite conclusion as to the *rationale* of the action, whether it is the massage employed, or the irritation produced, or the alkali absorbed, but the fact of the increased absorption under this treatment he considers undoubted (*London Med. Record*, Oct. 1882.)

The treatment of skin diseases by the inunction of soft soap, was a favorite one of the late Prof. Hebra of Vienna. I have been much pleased with the success of this mode of treating glandular enlargements, and, in the few cases I have tried it, have been amazed at the rapidity with which inflamed and indurated glands disappear.

Prof. Von Nussbaum, in cases of lymphatic swellings of the neck, after incision and evacuation of the pus, introduces iodoform freely into the wound with successful result. The iodoform has both a chemical and mechanical effect, setting up a local inflammation and inducing granulation of callous tissue. The iodoform should always be used as a coarse powder (*London Med. Record*, Nov. 1882).

I have found that painting lymphatic swellings with iodoform dissolved in flexile collodion (1 to 10) as recommended by Mr. Lennox Browne an excellent method. Two months ago a woman with greatly enlarged glands of the neck came to the General Hospital and was thus treated, the solution being painted on daily, after three weeks the glands were reduced by more than one half, in two weeks more there were only three or four glands to be felt, and these were not much larger than marbles.

New Antiseptics. Peat Dressings.—Prof. Esmarch has lately, at the suggestion of Dr. Neuber, used in his hospital at Kiel, bags of peat-dust impregnated with an antiseptic ; a small bag is placed over the wound and over this a larger bag is abjusted. These bags are retained in place by a gauze bandage, of late, however, Dr. Neuber has been using glass bandages. The first or smaller bag is filled with peat-dust impregnated with $2\frac{1}{2}$ per cent. of iodoform, and the larger or outer bag is filled with peat-dust soaked in a 5 p.c. carbolic solution. Such a dressing may remain undisturbed for from several days up to two weeks. Prof. Esmarch has used this dressing in fifty-five cases, among which were included seven resections and osteotomies, five amputations, twelve extirpations of tumours, and two herniotomies. The results are said to be most satisfactory. In only five cases was it necessary to remove the dressings. There was one death in a case of tabes dorsalis, where the operation of nerve stretching was followed by pyæmia. The advantages of the mould are that it is inexpensive, a powerful absorbent of gases and liquids, and that it checks decomposition. —*Lancet* and *Brit. Med. Journal.*

Naphthalin.—Owing to the numerous cases of poisoning which have followed the use of iodoform in German and Russian hospitals, a less dangerous substance is being sought for. Fischer & Djankonow recommend Naphthalin. They say it requires a less complicated apparatus and manipulation than other substances used in dressing, and is very much cheaper. Naphthalin a hydro-carbon, with the formula $\frac{C}{10}\ \frac{H}{8}$, is formed in large quantities in the distillation of coal and is found in heavy oils and coal tar. It is not soluble in acid or alkaline solutions,

nor in the secretion from wounds. It is freely soluble in cold ether, in warm alcohol, and strong sulphuric acid. Fischer first used these Naphthalin dressings in Strasburg, and came to the conclusion that it was a powerful antiseptic. It is a useful disinfectant for sick rooms, closets, &c. Djankonow has used it extensively and found it most useful in unhealthy granulating wounds and ulcers. The wound is first saturated with a 3 p.c. solution of chloride of zinc and then wool, dipped in Naphthalin, is laid on the wound and a bandage applied over it, then another layer of wool covered by oiled silk and lastly another bandage. Dr. Djankonow particularly recommends Naphthalin dressings for surgeons, who like himself, have to treat patients in hospitals deficient in funds and with an insufficient supply of nurses. —*Brit. Med. Journal*, Nov. 25th, 1882.

Oxide of Hydrogen.—This has of late been much used in France. M. Pean operates in an atmosphere of oxygenated water, instead of carbolic acid. M. Baldy employs gauze and wool soaked in the peroxide. It has been successfully used by ophthalmologists, and many French surgeons use it for washing and dressing ulcers and abcesses. It was first (New York *Medical Record*, January 6th, 1883) introduced by Mr. C. G. Kingsett of London, in 1876. Much is hoped for it as an inhalation in pulmonary troubles.

Cholecystotomy and Floating Kidney.—Abdominal surgery is still making progress, in fact, we are only now realizing what great possibilities there are in this field of surgery. The whole or part of every organ in this cavity has been at one time or other removed, with one exception, viz, the pancreas. Mr. Lawson Tait (*Lancet*, Nov. 18th, 1882), has reported his third and fourth cases of incision of the gall bladder. The third case, a lady, aged 28, was by many eminent men, (whose names, with questionable taste he mentions), diagnosed as a case of floating kidney, but Mr. Lawson Tait has "no belief in its (floating kidney) existence as a pathological incident," having never seen such a thing, either in life or a museum, or never having met any one who has. Without difficulty he made the diagnosis of gall-bladder, distended by occlusion of the duct by a calculus.

He opened the abdomen over the tumour by a vertical incision, and came at once on the distended gall-bladder, and removed a pint of glairy mucus from it with an aspirator, then laid it open and took out 80 gall stones. The aperture in the gall-bladder was then stitched to the wound in the abdominal wall, and the peritoneum carefully closed and a drainage tube left in the gall-bladder. The patient's recovery was uninterrupted and in three weeks only a small sinus was left, the patient having gained flesh and being free from pain. No antiseptics were used.

The fourth case was similar to the last; a tumour could be occasionally seen in the position of the gall-bladder, and the woman (age 37), suffered intermittingly from severe attacks of colic. On cutting down and opening the gall-bladder, 16 gall stones were removed. The drainage tube was taken out on the fourth day, and in ten days the wound was almost healed.

Mr. Tait's opinion with regard to the occurence of floating kidneys is, to say the least, remarkable. I have certainly seen them in *post-mortem* examinations, and numberless cases of their removal or fixation are on record. The last case of fixation is reported by Dr. Weir in the New York *Medical Journal* of Feb. 17th, 1883. Landau (1881) reports 314 cases. Dr. Harris of Philadelphia tabulates 18 cases of nephrectomy for the relief of symptoms due to displaced kidney.

Dr. Wm. M. Polk, (New York *Medical Record*, Feb. 17th, 1883), reports an interesting case of *Removal of a Congenitally Displaced Kidney*, (in a girl age 19), which was felt in the left iliac fossa and caused such severe pain that it was necessary to keep her under morphia. The kidney was successfully removed and the patient lived eleven days. She passed no urine after the operation. The *post-mortem* examination revealed the sad fact that her *only* kidney had been removed. There was also absence of the vagina and uterus. This had been diagnosed before the operation.

Extirpation of the Gall-Bladder.—Dr. Carl Langenbuch, (*Berlin Klin. Woch.*, Nov. 1880), has indicated a method, (illustrated by a successful case) of *extirpation of the gall-blad-*

der. An incision is made in the right hypochondrium parallel to the lower border of the liver, and joined by a second incision running along the outer border of the right abdominal rectus muscle. The abdominal cavity being thus opened the transverse colon and small intestines are pushed aside by a large sponge and the liver elevated, so as to bring the hepatico-duodenal ligament into prominence. The gall-bladder is then easily separated from the liver by a few strokes of the knife, and the cystic duct laid free and ligated in two places with silk threads; catgut should not be employed. After removal of the gall-bladder, the wound in the abdomen is closed and the operation completed. Strict antiseptic precautions employed. The case in which this procedure was practised, was that of a man aged 43, who for fifteen years suffered from calculous formations in the gall-bladder, healing was completed in two weeks, since then his general health has greatly improved and he has gained 15 lbs. in six weeks. He has no pain and has entirely given up the use of morphia, which before the operation, had been constantly employed in large quantities.—*American Journal of Medical Sciences*, Jan., 1883.

Total Excision of the Sternum.—At the recent Congress of German Naturalists, at Eisenach, Prof. Kœnig reported a case in which a woman had been treated by several physicians, for more than two years, for a sternal tumour which, without being excessively painful, gave great uneasiness from its steady increase in size. The tumour was as large as a child's fist, was moderately hard and clearly arose from the sternum, and passed laterally into the ribs. It was sarcomatous in nature. It was decided to remove the sternum after experimenting on rabbits. The operation consisted first in the division of each rib near the sternum. A slight opening was made in the right pleura, and on further dissecting it was found that the pericardium was adherent to the tumour, and it was accidentally torn, as was also the left pleura. In spite of these openings the patient was only dyspnœic for a few moments. The wound was then closed after the removal of the sternum and dressed with iodoform. The dressing was not disturbed for 12 days, when it was found

that part of the skin had sloughed, and that the heart was bathed in pus. Improvement was steady, and the patient was shown to the Congress with the wound quite healed. (*All. Wiener Med. Zeit.*, Sept. 1882; quoted in *American Jour. Med. Sciences*, January 1883.) This is a remarkable operation, and the successful result makes it justifiable; but another European surgeon, who lately extirpated a portion of lung for phthisis and lost his patient, has been much criticised, and the operation is now being made the subject of a judicial investigation.

Amputation at the Hip Joint.—Notwithstanding the very great advances made of late years in operative surgery, this operation is still a very fatal one, and one which the surgeon undertakes only after the most careful consideration. The control of hemorrhage is still the chief difficulty. Davy's lever, it was thought at one time, would make the operation an almost bloodless one, and therefore lessen the risk. But of late two fatal cases have been reported, death being due to peritonitis. On post-mortem examination it was found that the lever had torn through the rectum and perforated the periteneum. In the last fatal case Mr. Davy himself was the one who manipulated the lever. The right side artery was compressed. As the rectum lies to the left side of the pelvis, in passing the lever up the rectum to compress the right common iliac artery, the bowel would have to be put considerably on the stretch, and so the risk of rupture would be much greater than if the left artery had to be compressed. These cases have destroyed the confidence of the profession in the usefulness of the lever, at least for compressing the right iliac artery. It may still probably be used with safety to compress the left iliac artery.

Dr. MacLaren (*Brit. Med. Journal*, Jany. 27, 1883) reports a successful case of amputation of the hip for necrosis of the femur in a child six years and eight months old. Mr. Furneaux Jordan's method was employed; that is dissecting out the thigh bone by a vertical incision, and making the circular incision through the soft parts some distance down. Davy's lever was used to compress the right iliac artery, and answered admirably,

hardly any blood being lost. This is Dr. MacLaren's fourth case, with one death.

Mr. Lewis Marshall (*Brit. Med. Jour.*, Oct. 1883) reports four cases of amputation at the hip by Mr. Furneaux Jordan's method. All were in children—two aged seven, one aged five, and one aged two years and five months. In all, the fingers were used to compress the femoral. No more than two vessels were ligatured in any instance. Two drachms would represent the maximum blood loss. Catgut ligatures were used, and the wounds dressed with carbolic oil and lint. One case died three months after the operation from visceral lesions. Mr. Marshall fully agrees with Mr. Jordan that in this method of operating there is less shock, less hemorrhage and less opportunity for septic infection. The vessels cut are more easily dealt with. It should only be employed where the soft parts are intact. Mr. Jordan holds the danger is much less when the femur is enucleated and the soft parts cut across at some distance from the hip joint and where they are smaller. The stump, though at first flaccid and limp, soon retracts. Mr. Marshall says his chief object in bringing these cases forward is to call attention to the somewhat tardy manner this method has been adopted by the profession, while all the London surgeons are endeavouring to find means of arresting hemorrhage from the posterior flap, they never even give this method, in which wounding of the gluteal vessels is altogether avoided, a trial. [Mr. Jordan's method is fully described in his book on "Surgical Inquiries," and in the *Lancet* of March 23, 1879.]

Mr. Shuter, at a late meeting of the Clinical Society in London (*Brit. Med. Jour.*, Feb. 17, 1883), reports a case of subperiosteal amputation at the hip, performed after Jordan's method. The patient recovered, with new bone in the stump. When shown to the Society, he could walk easily by means of an artificial limb which was attached to the stump.

Dr. R. Varick (*Am. Jour. of Med. Sci.*, Oct. 1882) reports a case of amputation of the hip joint, with recovery, Trendelenburg's method of controlling hemorrhage being resorted to. The method is as follows: A steel rod is passed obliquely through

the soft parts between the femur and the femoral artery, coming out at the fold of the scrotum. An elastic band or tube is now wound in figure of eight fashion round the ends of the rod passing in front of the thigh, the knife is then introduced and the anterior flap formed. Having ligated the vessels and removed the compressing band and rod, the femur is next disarticulated, and the posterior flap formed in like manner. Dr. Varick says this is the first operation performed in this way in America. It was done for a case of compound fracture of the right leg and thigh, with considerable laceration of the soft parts.

Question as to Amputation.—Mr. Wm. S. Savory, F.R.S., in a short paper (*Lancet*, Jan. 6, 1883) remarks that perhaps in no case is the judgment of the surgeon more severely taxed than when he is called on to decide the question of amputation in an injury to a limb. Mr. Savory says, in endeavouring to form a judgment in such cases one has to consider, first of all, whether the injury is greater than the operation for its removal. If the injury be greater, then of course amputation should not be thought of. Secondly, if operation be decided on, is the chance of recovery from the operation so much greater as to cover the risk from the second shock which the operation would necessarily cause? It was formerly held that less risk to life is incurred by operating immediately after the injury than at a remote period; but Mr. Savory thinks that opinion on this question has gradually changed, owing to the different experience civil surgeons have had from military, who always advocated primary amputations. In attempting to save a limb, we should consider "whether it is worth while, for the prospect of such future use in the limb that might remain to him, for a man to run, in order to preserve it, any additional risk of his life, and if so, to what extent?" With regard to secondary amputations he says: "Secondary amputations are more favorable than primary ones when there is a choice of time—that is, when we can afford to wait till the temperature and other signs of general disturbance have subsided; but secondary amputations are less favorable than primary if the operation is forced upon us at a period in the case when a high degree of fever still prevails.

Herein, too, lies the difference in the prospect between secondary amputation after injury and amputation in disease, for in the latter case there is almost always a choice of time."

In the *Lancet* of Feb. 3rd, 1883, Mr. Savory, when speaking of *Symes' Amputation*, says the tendency of surgeons of the present day is to make the incision in the sole of the foot obliquely backwards at the expense of the flap, and thus lose a considerable portion of the thick integument of this region, which makes such a capital pad. This change is due to the fact that the further back the surgeon goes in his incision, the less difficulty he will have in dissecting off the integument from the heel. But this difficulty may be overcome, after making the incisions, by opening the joint and working from above down. The dissection is thus rendered comparatively easy, and there is no danger of scoring the flap. I have seen this method of dissecting off the heel-flap performed many times in Germany, and have taught it in my operative surgery class for the last six years. In addition to the method of dissecting the flap, the incision for the heel flap in Vienna is always commenced by making a transverse incision on the plantar surface of the heel, as far forwards as the line of the tip of the external malleolus, and then extending the incision to the required point on each side. In this way there is no temptation to sacrifice the heel flap. In the same article, Mr. Savory, in speaking on *Ligature of Arteries in their continuity*, condemns the present practice of, after making the preliminary incisions, laying aside the knife and then endeavoring to expose the artery by tearing through the intervening tissues with a director. He points out that it is almost impossible to avoid bruising the artery or vein, or to make a clean and satisfactory isolation of the artery by this plan, and prefers the old-fashioned method of using the knife to expose the artery. He has never seen the artery cut by the knife, even when it has been used freely in awkward hands, but has seen the artery injured on the living and dead by the abuse of the director. Mr. Savory also prefers carrying the needle round the artery without the ligature, and passing the thread through it afterwards.

Treatment of Frost-bite.—Dr. Lapatin of Tiflis makes known

a remedy which, he says, never fails, if mortification has not set in (*Phila. Med. Rep.*, Oct., 1882). This is Balsam of Copaiba. It should be spread thickly on a piece of muslin or linen, and the affected parts covered with it during the night, a stocking being put over the whole. In daytime some balsam is merely spread over the parts. After one or two applications, the redness and pain cease, and a few more not only remove every sequelæ, but seem to impart to the surface a remarkably increased resistance against frost-bite, if common precautions are used. I have employed this in one case, but as the patient never returned to hospital, I cannot give the result.

Treatment of Soft Chancres and Buboes.—Antier states that salicylic acid is highly efficacious as an application to soft chancres and buboes. It is odorless, only slightly painful in its application, soluble in alcohol and glycerine, and leaves no stain upon linen. (*Practitioner*, Feb'y, 1883.) This application might be of use in those cases of chancres where iodoform appears to irritate, or where the odor is objected to.

Surgical Treatment of Mammary Tumors.—Surgeons are beginning to lose confidence in the method of removing cancerous mammary glands which has lately been in vogue. The dissecting out of the gland neatly, and sewing up the skin so that healing takes place by first intention, and the patient discharged cured in 10 to 15 days, is all very well for the time, but is it the safest method? and is the disease wholly extirpated? I think not, as a rule, judging from the time that elapses between the operation and the fatal issue. A surgeon, perhaps, reports 20 or 30 cases of excision of cancerous mammæ, and glories in the fact that in all, union was by first intention, and that the average time each patient was under treatment was only, say, two weeks; but he does not write a sequel, telling us of the condition of these same patients a year or two after. The tendency of surgeons of the present day is to report cases or series of cases too soon after operation, and the final result is rarely published. One can easily see what fallacies we may fall into by adopting such methods, and how little benefit these hastily prepared papers are to the community. Dr. Mitchell Banks (*Brit. Medical Jour.*,

Dec. 9, '82), asserts that surgeons, as a rule, do not remove cancers of the breast; they persuade patients that they do, and almost persuade themselves. He says if we look at the surgical works of a hundred and fifty to two hundred years ago, the true method of removing a cancerous breast will be found. The breast was laid hold of with great cutting pincers, and having been cut clean off, the raw surface was rubbed over with a red-hot poker. Dr. Banks advises that if the cancerous lump be deep, then some of the skin at the margins of the breast may be kept; but, if any part of the skin be involved, then a circle should be drawn round the breast, and it should be cut clean off without the remotest regard to flaps or coverings of any kind. The breast wound being settled, the incision should be carried into the axilla about an inch below the margin of the great pectoral muscle, and all the glands removed, whether enlarged or not. He has come to the conclusion that, *in every case where the breast is removed, the axilla should be cleaned out as a necessary accompaniment.* The one operation is useless without the other. As you cannot tell whether the glands are diseased or not, remove them and dissipate the doubt. Dr. Banks has records of 46 cases, with 6 deaths; he admits this is a serious mortality (13 per cent.), but adds that if the operation is to be of any service at all, it cannot be otherwise than a serious one. Five cases died of septicæmia and erysipelas, and one of bronchitis. All the fatal cases were from 44 to 67 years of age, and they died from three to six weeks after the operation. In 11 cases the patients died from recurrence of the disease in from 3 to 12 months. Three cases died from one year and two months to two years after the operation from other diseases. Ten cases are still alive without return, in whom the operation has been performed 2 to 10 years, and three are alive on whom the operation has been performed one to two years. Nine cases on whom the operation was performed within the year are not tabulated, and one case has been lost sight of. Dr. Banks thinks if going to reappear, it will generally do so under 18 months. Gross says if the patient lives three years, the probability is that it will not recur, and the author agrees with him, and adds that it is a perfect de-

lusion that the operation prolongs life even if the disease reappears. Although Dr. Banks usually practises Listerism, he does not do so in these cases, because he says the spray seriously lowers the temperature and vitality of the patient on account of the exposed condition of the upper part of the body for the 30 or 40 minutes which this operation should take. He contents himself with simply washing the wound well with carbolic lotion.

Prof. McLane Tiffinay (*Maryland Med. Journal*, Jan., '83) reports 30 cases of mammary tumors operated on by him during the last eight and a-half years, only about half being malignant. Twenty-seven cases were in whites and only three in mulattoes. He remarks that mammary tumor in the full-blooded negro is extremely rare. In all the cases the tumor was excised, and all recovered from the operation. Many have since been lost sight of, but of the cases of malignant tumors, one is alive four years after operation, without recurrence, and one case the disease returned four years and a half after operation. The growth was a second time removed, and patient continues well to the present time. Dr. Tiffinay is a strong advocate for removal of all the glands in the axilla in cases of carcinoma, even if they do not appear diseased to the naked eye. He also agrees with Gross in thinking that union by first intention after operation is not so much to be considered as the free removal of the disease.

Dr. Sprengel (*Archiv f. Klin. Chir.*, 1882) has carefully analyzed 131 cases of mammary cancer operated on in Volkmann's Klinik from 1874 to '78; 112 were married, 8 of whom had never borne children. Of 98 cases, 21 had mastitis once, four more than once, and in four both mammæ had been inflamed. Sprengel concludes that puerperal mastitis most often predisposes to mammary cancer. In 44 cases, traumatism was alleged as the cause, but Sprengel says this must be accepted with reserve. There was a clear history of heredity in 109 cases. The tumor affected the right breast 56 times, and the left 75. It is stated that the carcinomata developing in immediate connection with pregnancy and lactation ran a peculiarly malignant course. The skin was always involved earlier than the muscular tissue. The rule that the entire gland should be removed was only twice de-

parted from. The results of 131 cases, with 200 operations (including secondary operations), were 10 deaths—one from shock, two from embolism of the lungs, one from hæmatemesis, one gangrene, one erysipelas, and four from septicæmia. Recurrence took place most often within six months of the operation; 15 cases are reported cured, 13 remain free three years after the operation, and of the other two, one died of cancer of the opposite breast and one of a tumor entirely distinct from the original disease three years after operation. In 29 cases where the axillary glands were not involved, six were cured; but of 102 cases where the glands were affected, only nine had a like favorable result.—*Centralblatt f. Chir.*, July, 1882.

These results are not very encouraging to the operating surgeon; still, if even 10 per cent. recover, the operation is quite justifiable, though no doubt, while some lives are saved by the operation, others are considerably shortened. Mr. Banks had 10 out of 46 cases operated on by the method of removal of the whole breast and axilla living from two to ten years after, which is a considerably better result. However, in Volkmann's cases, the ones living since being operated on in 1878 are not included in his list.

Hospital Reports.

MEDICAL AND SURGICAL CASES OCCURRING IN THE PRACTICE OF THE MONTREAL GENERAL HOSPITAL.

SURGICAL CASES UNDER THE CARE OF DR. RODDICK.

Two Cases of Stone in the Bladder—Lateral Lithotomy—Recovery.—Reported by DR. T. N. MCLEAN, House Surgeon.

Clinical Clerk and Dresser, Mr. J. C. Bowser.

CASE I.—George T., æt. 6, was admitted into hospital March 9, 1882, suffering from pain over pubes and in perineum; also incontinence of urine. Patient is a well nourished, healthy looking boy. Has always been very healthy till two years ago, when present trouble began. Parents say that during past two years he has never passed his urine in a stream, but it constantly dribbles away. Clothing is always wet. Suffers from

very severe pain in perineum and in hypogostric region. When the pain is very severe he lies on his face and draws on the penis; wakes up with these pains two or three times every night. And during the day jumping and tumbling about always brings on an attack. Has never complained of pain in point of penis; no history of renal colic. Never passed any blood; never suffered from retention of urine, nor prolapse of rectum. Prepuce is very much elongated. As he lies in bed one notices a few drops of urine pass from penis every two or three minutes. Comes away in this manner all the time.

Feb. 10*th.*—Was etherized to-day and a sound passed, when a large, hard, rough stone was felt. To have castor oil to-night followed by an enema in the morning.

11*th.*—Patient was etherized to-day, when Dr. Roddick, assisted by Drs. Fenwick, Ross and Shepherd, proceeded to do a lateral lithotomy. Operation was not complicated: no hemorrhage. A stone weighing fifty-seven grains was removed, which was very rough and hard, consisting wholly of uric acid. Patient was put to bed, and a sponge soaked in a warm solution of carbolic acid was applied to the wound. No tube left in the wound. 8 *p.m.*—Is feeling very comfortable; no hemorrhage; urine is passing through the wound.

12*th.*—Rested fairly well. Very little pain. T. 99°F, last night 99½°F, this morning pulse 100. Urine is coming away nicely through the wound; sponge was changed about every three hours.

13*th.*—T. 102°F this morning; pulse 110. Complains of pain over region of the bladder, which is very tender. Urine has not been passing through the wound since midnight. Bladder appears to be slightly distended. Ether was administered and a gum-elastic catheter was passed through the wound into the bladder, followed by the introduction of the little finger, the intention being to re-open the wound thoroughly; to have hot poultices applied over the region of the bladder. 8 *p.m.*—Feels much more comfortable, urine is passing through the wound.

14*th.*—Wound is closed up this morning again. A small amount of urine passed through the urethra this morning. A

gum-elastic catheter was passed through the wound again, to re-open it. Surface of wound looks very unhealthy ; is covered by a dirty greyish diphtheritic looking membrane. No discoloration or thickening around the wound. Tenderness over region of bladder is much less to-day. T. 102½°F, pulse 118. To have wound washed, every four hours, with acid carbolic ℥ss, glycerine ℥i. Iron to be given internally.

16*th.*—Is feeling much better to-day. T. 98½°F ; pulse 118. Hypogastric tenderness all gone ; poultices discontinued ; urine is passing through the urethra now. Surface of wound looks much healthier. To be dressed with iodoform.

Patient made an excellent recovery. Incontinence of urine and pain all disappeared. Left hospital Dec. 14, 1882.

Clinical Clerk and Dresser, Mr. E. S. Wood.

Case II.—Allan M., aged 20, farmer, was admitted into hospital Jan. 26, 1883, complaining of severe pain in perineum, and frequent micturition, which has troubled him since he was five years of age. Patient is a well developed, healthy looking young man. Has always been quite healthy till present trouble began, which was fifteen years ago. Says he has to get up three or four times every night to micturate, and very often during the day. Has always suffered from pain in point of penis after micturition ; stream often stops suddenly ; often notices that he passes a small amount of blood, especially after exercise. Pain in hypogastric region and in perineum is often very severe, especially after riding in a wagon or on horseback. When his pain is so severe, he says he lies on his stomach which relieves him. Has never had any prolapse of rectum ; no history of renal colic. To have castor oil to-night, followed by an enema in the morning.

Jan. 27*th.*—Was etherized and sounded to-day, when a large, hard, rough stone was felt.

31*st.*—To have castor oil to-night, followed by an enema in the morning.

Feb. 1*st.*—Ether was administered to-day, when Dr. Roddick, assisted by Drs. Fenwick and Shepherd, performed lateral

lithotomy, and removed a hard, rough stone, as large as a hen's egg, weighing nine drachms. Stone was composed entirely of oxalate of lime. Operation was not complicated. There was slight oozing, but it was easily counteracted by applying hot water to wound. A silver tube was passed through the wound into the bladder, and retained to drain off the urine. To have a hot carbolized sponge applied to wound, and internally to have Tr. Aconite (B.P.) ♏v; 2 q.h. 8 *p.m.*—Complains of pain; no hemorrhage. Gave Liq. opii sed. ♏x hypodermically.

2nd.—Slept well all night. Feels very comfortable this morning. No pain; no hemorrhage. T. 100°F last night, and 101°F this morning; pulse 80. Tube was taken out, thoroughly cleansed and re-introduced. Urine draws away nicely.

3rd.—Had a very good night. T. 102° last night, 98° this morning. Aconite to be discontinued.

5th.—Tube removed to-day, wound looks quite healthy. Says he has not been so free from pain for years. T. 98°F; pulse 80.

12th.—Passes his urine through the urethra without any pain, occasionally a drop or two passes through the wound. Wound to be dressed with iodoform.

18th.—Feels quite better; wound is almost all healed. To have his clothes to-day.

21st.—Discharged cured.

Remarks by Dr. Roddick.—It will be noticed in connection with the first case that much trouble resulted from too rapid closure of the wound, and from the presence doubtless of blood clot. This I have known to occur in more than one of my previous cases, causing troublesome retention and feverish symptoms. In the second case, however, these were obviated by the introduction of a tube, and I am disposed to think that the latter is, in all cases, the safer practice. The occurrence of diphtheritic exudation on the wound in the first case is also a point of some clinical interest, as well as its rapid disappearance under the treatment ordinarily adopted in the hospital for diphtheria. It might be mentioned that several cases of the disease were under treatment in the hospital at the time.

MEDICAL CASE UNDER CARE OF DR. ROSS.

Syphiloma of the Brain—Hæmiparesis and Clonic Spasms—Choked Disc—Rapid Improvement.—Reported by Dr. J. A. MacDonald, House Physician.

H. B., aged 52, admitted Dec. 12, 1882, complaining of severe headache in the left frontal region, with some weakness of right side. Present trouble began with headache about one year ago. At first the headaches were not severe, and he was able to be about his work. In June last, headache so severe that he had to give up work, and spend most of time in bed. Headache always worse at night, and about this time he suffered from noises in the ears and beginning failure of sight. Was under medical treatment, and at the end of three months was so far improved as to be about his work again, but still suffered from his head. On Oct. 29th, while going down stairs, became dizzy and fell a few steps; was seized with what from his description was probably an attack of clonic spasms of right side; did not loose consciousness; spasms lasted three hours. Next day he was able to walk, but from that time his right arm and leg were weak. On Nov. 26th had another attack of spasms of right side. After this attack side was weaker, but was still able to walk. On Dec. 9th another attack of spasms, and since then walked very badly, and finds that besides weakness of right arm there is some inco-ordination. Has never been free from headache, but not so severe as he had in the summer; always worse at night, and usually confined to left frontal region. No pain or abnormal sensations in extremities. No history of syphilis.

Patient is a rather aged-looking man. Marked arcus senilis. Left eye blind, due to some old corneal affection; stands with difficulty, and if not supported is inclined to stagger backward; it is not more difficult to stand with eyes closed than open. Walks with left foot in front of right, and if he attempts to bring right foot to the front he staggers backwards; as he moves forward the left foot is lifted clear from the ground, and the right dragged after. While lying in bed it is seen that

right leg is very much weaker than left. Right arm is about half the strength of left, and there is marked inco-ordination; cannot feed himself with right hand; tell him to touch an object in front of him and he lifts the hand close to it, and only after fumbling about for a time finds it. No ankle clonus; tendon reflex of left knee slightly increased; that of right very much so. Sensation is good; muscles are small, but no special wasting on right side. Optic disc considerably congested and outlines indistinct. Several choroidal patches, indicative of old syphilis; no scars of syphilis anywhere about body; urine contains no albumen; heart normal; arteries slightly fibroid; temperature normal; pulse 78; respiration 18.

Dec. 17*th.*—Patient had one of the attacks of clonic spasms he describes; was confined to right side, and lasted about half an hour. General condition is about the same; headache very severe, and so bad at night as to require opiates.

Dec. 19*th.*—Another slight attack of spams of right side. Ordered Pot. Iod. gr. xx; Potass. Bromid. gr. x, t.i.d.

Dec. 22*nd.*—Slight spasms again.

Dec. 26*th.*—Headaches not so bad; still requires opiate at night. Walked decidedly better; can now bring right foot in front of left; foot does not drag so much. Arm improving.

Jan. 8*th.*—Patient was discharged from hospital to-day. Since last note made rapid and steady improvement; no headaches. Uses arms and legs perfectly, though right side still a little the weakest; patellar reflex still exaggerated. Has reported himself several times since; continues well.

REMARKS.

Although in this patient there were no evidences whatever of past syphilis, either from history or remains of ancient lesions, still it was thought from other circumstances that the probability of his having suffered in this way was very great. Besides, as Dr. Buller has recently strongly urged, the existence of optic neuritis of itself was an indication for the exhibition of Potass. Iodid. The case shows the admirable results obtained from this drug, in a very severe case of cerebral disorder of only doubtful syphlitic origin.

Reviews and Notices of Books.

The incidental effects of Drugs, a Pharmacological and Clinical Hand-Book. By Dr. L. Lewin, Assistant at the Pharmacological Institute of the University of Berlin, Translated by W. T. Alexander, M.D., New York: Wm. Wood & Co.

This book is an entirely original contribution by an original worker, upon a subject to which but little attention has ever been directed, and which yet is of much interest and may often assume even great importance. From repeated experiments, and from prolonged clinical observations, we have had deduced for us the typical actions of all the drugs of our Pharmacopœia. This is what is set before us in the systematic delineation of a Materia Medica. "But," to quote from the author's preface, "in the therapeutic employment of certain drugs, deviations sometimes occur from this typical and, as one may say, normal action, whose recognition and correct interpretation are not always easy. A knowledge of them is, however, of great importance to the physician, since they may, in a given case, shed light upon the cause of the unexpected phenomena which show themselves, and also furnish indications to guide him in his practical interference." Every physician of experience can fully corrobate the statement, and will admit, how puzzling it sometimes becomes to disentangle symptoms and determine what are certainly produced by the malady itself, and what by possible effects of drugs which have been administered. In a short notice of this kind it is impossible to particularize in order to show further the scope of such a work, and its character can readily be gathered from the foregoing remarks. The various classes of drugs are taken up *seriatim*, and the most important members of each selected for discussion. Great numbers of references are given to recorded cases, illustrating the peculiar or abnormal effects stated to have been produced. As it is not sufficient for a physician to have a knowledge only of the typical forms of disease, for he must also study and observe cases differing from these types, so he should also be familiar with the

occasional freaks known to occur as results of the exhibition of medicinal substances. Lewin's treatise shows much research and extended observation, and, in every section will be found much to repay perusal.

Lectures on Electricity (Dynamic and Franklinic) in its relations to Medicine and Surgery.—By A. D. Rockwell, A.M., M.D., Electro-therapeutist to the N. Y. State Women's Hospital: Member of the American Neurological Society, &c. New York: Wm. Wood & Co.

This is an excellent manual on the practical use of electricity, written by an experienced operator. It contains in well arranged order, short and clear instruction upon all points necessary for the information of the practitioner on the general principles of the subject, which is followed by references to the use of this agent in various special diseases. Electrical technicality is abstained from as much as is possible, compatible with making the subject understood. Some novelties are also introduced, especially a lecture upon the employment of Franklinic electricity, some authorities believing that by means of sparks and shocks certain results can be procured which are otherwise unattainable. The surgical department receives its due share of notice, and a new instrument is described called a galvanic accumulator, which has been made use of by the author for the cautery-wire. If found to work well, this will surely come into vogue amongst operators from being so handy and compact. We can recommend Dr. Rockwell's lectures to all practical men desirous of being safely guided in this special department.

The Illustrated Quarterly of Medicine and Surgery. Edited by Geo. Henry Fox and Frederic R. Sturgis. Vol. I., No. IV., and Vol. II., No. I. New York: E. B. Treat.

Interesting and rare cases continue to be illustrated and treated of in this popular journal. The present numbers contain the following:—No. IV. has articles on sarcoma of the breast and of the pharynx, by Drs. Bull and Stinson; a club-foot case

by Prof. Sayre ; on syphilitic ulcerations in the upper air-passages, by Dr. Carl Seiler. A remarkable example of laryngo-tracheal diphtheria in an adult, by Dr. Cheeseman ; cases of empyema by Drs. Ranney and Mears, and a communication on some peculiar tumors of the hands, by Dr. Rex.

No. I. contains a paper on Dental Development, by Dr. Wm. Hailes, Jr. ; palato-pharyngeal sarcoma, by Dr. Eliot ; excision of the shoulder-joint, by Dr. Winslow ; complicated hair-lip, by Dr. Little ; cysto-adenoma of the thyroid gland, by Dr. Chas. Buckley ; secondary myeloid disease of pleura and lung, by Drs. Osler and Ross (of Montreal) ; congenital union of the fingers, by Dr. Posby ; a teratological contribution, by Dr. Engelmann ; and apparatus for fracture of the patella, by Dr. Wright. The lithographs and wood-cuts introduced continue to present the same excellent appearance as hitherto.

A Treatise on Fractures.—By Lewis A. Stimson, B.A., M:D., Professor of Surgical Pathology, Medical Faculty, University of the City of New York ; Surgeon to Bellevue and Presbyterian Hospitals ; Member of the New York Surgical Society. With 360 illustrations on wood. Philadelphia : Henry C. Lea's Son & Co. Montreal : Dawson Brothers.

Dr. Stimson has long been known to the profession as the author of a remarkably practical little work on " Operative Surgery," and hence comes to us again as an old friend in a new garment, and we find him fully as welcome now as he was before. The author does not trouble us with a long preface and a host of apologies for his publication, but seems to have just conceived the idea of writing a book on Fractures, and then at once dived *in medias res.* The matter is admirably arranged, and the wood-cuts are very good. Of course, as must naturally occur, very much of the material is a mere *resumé* of the experience of others, but this is judiciously selected.

In the chapter on the " remote consequences of fracture," we find a section devoted to the interesting pathological condition known as *fat embolism.* It is to be regretted that the case

recently reported by Dr. Rodger of this city was not known to the author, as it would have added somewhat to the value of the article. In the same chapter, reference is made to the *inclusion of nerves in the callus*—an accident of more frequent occurrence than is generally known. We happen to have just now, in private, two cases of fracture of the lower end of the humerus, in which the ulnar nerve has become involved in the callus, and the functions of the nerve seriously impaired. In due course we purpose cutting down and attempting to release the nerve. In the treatment of fractures of the vertebræ, the author strongly recommends the gypsum jacket, but has not seen much benefit from extension. In the case of fracture of the clavicle, the form of dressing preferred appears to be that recommended by Sayre, and we are quite in accord with the author here, although we have long contended that without rest in bed no apparatus will succeed in every case.

Altogether, the author seems to have had a thorough conception of what should constitute a practical treatise on fractures, and carries it out in a most satisfactory manner. The work is one which we feel certain will be read with interest and profit by all.

Materia Medica and Therapeutics. Inorganic Substances. By Charles D. F. Phillips, M.D., M.R.C.P. Late Lecturer on Materia Medica and Therapeutics at the Westminster Hospital Medical School. Edited and adapted to the U.S. Pharmacopœia by Lawrence Johnson, A.M., M.D., Lecturer on Medical Botany, Medical Department of the University of the City of New York. Vols. I and II. New York: Wm. Wood & Co.

These volumes form a continuation to that which was published from the same author, including "the Vegetable King dom," in Wood's Library of Standard Medical authors. They belong also to the same series and bear the impress of the same thoroughness and care in preparation which characterized that just alluded to. They form a most complete and reliable guide to this portion of the Materia Medica. The therapeutical

portion of the treatise is particularly full and brings forward all the most modern ideas concerning the methods of employment of and indications for, our various remedial agents.

Transactions of the American Ophthalmological Society.—18th Annual Meeting, 1882. New York: Published by the Society.

This series of papers forms together a little volume of 120 pages, full of interest to the specialist and containing also, much that is of value to the general practioner. Pulsating tumor of the orbit, treated by electrolysis, by Dr. Bull; cases of tumor of the eye, by Dr. Hayes; sarcoma of the lachrymal gland, by Dr. Harlan, are all well worthy of notice from surgeons. Dr. Loring, of New York, contributes a paper upon the induction of premature delivery for the prevention of blindness. He describes cases exemplifying the very serious results produced in the retinæ of patients who have become uræmic during pregmancy, and lays down important practical rules with reference to the course which should be adopted in order to obviate these. Dr. Buller, lecturer on Ophthalmology at McGill University, describes a very singular case of alopecia of the eyelids and furnishes a plate of the microscopical appearances. These are a few only selected from the transactions, which appear to have been of unusual interest.

Books and Pamphlets Received.

Medical Diagnosis. By J. Graham Brown, MD. Edinburgh: Bell & Bradfute. Toronto: Carswell & Co.

The Immediate use of the Uterine Scoop or Curette in the Treatment of Abortions *versus* Waiting, or the Expectant Plan. By T. Johnson Alloway, M.D., L.R.C.S. and P., Edin.

The Immediate Removal of the Secundines after Abortion. By Paul F. Mundé, M.D. Reprints from "The American Journal of Obstetrics and Diseases of Women and Children." February 1883.

A Practical Treatise on Diseases of the Skin, for the use of Students and Practitioners. By James Nevins Hyde, A.M., M.D. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Bros.

Scrofula and its Gland Diseases, an Introduction to the General Pathology of Scrofula, with an Account of the Histology, Diagnosis and Treatment of its Glandular Affections. By Frederick Treves, F.R.C.S, Eng. Philadelphia: Henry C. Lea's Son & Co.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, February 2nd, 1883.

Dr. T. G. Roddick, Vice-President, in the Chair.

Dr. Gardner exhibited the following specimens :—

1. *Fibroma of both Ovaries and Uterus*, occurring in the practice of Dr. Mullin of Hamilton. The specimen was removed *post-mortem*. Each ovary is of the size of a child's head. One ovary was impacted in the pelvis ; the other could be felt through the abdomen as a hard, movable tumor projecting above the brim. The morbid growth consists apparently of an expansion of the whole ovary rather than an outgrowth from the organ. The fibroma of the uterus is a small subperitoneal outgrowth. In structure the tumors are very dense, and present all the characters of fibromata. Dr. Mullin promises a full report of the case. Dr. Gardner remarked that the specimen was one of exceedingly great interest, from its rarity of both nature and size. The most exhaustive articles on the subject he knew of were Leopold's paper in the 6th Vol. of the Berlin *Archives für Gynecology*, published in 1876, and a paper by Dr. Coe in the *Am. Jour. of Obstet.* for July and October, 1882. Leopold had collected 56 cases of solid tumors of the ovary of all kinds of fibroma—carcinoma, enchondroma, and sarcoma—and from the reports at his command, which, however, were derived from the statistics of ovariotomists, he estimated that they constituted about 1.5 per cent. of all ovarian tumors. As, however, the tumors do not always attain a size calling for surgical interference, it is probable that if the records of *post-mortem* examinations were also taken, the proportion would be somewhat increased.

2. *A Uterus of normal size, with two small submucous fibroids projecting into the cavity of the body, and a smaller one projecting into the cavity of the cervix.*—One of those in the body is situated near to the internal os, which, however, it does not appear to have obstructed.

3. *An imperfectly developed Uterus, with an interstitial fibroma almost subperitoneal, of the size of a hazel nut, in the*

fundus.—In neither of these latter cases was there a history of any symptoms having been caused by the tumors. Dr. Osler, speaking of the frequent occurrence of these small fibroids, ventured to say that over half of the women over fifty would have fibroids, they are so excessively common.

4. *A Fibrocellular Polypus of the size of a small orange*, which he had removed a fortnight ago from a lady of over sixty years of age. It was attached by a short, thin pedicle to the posterior wall of the cervix, a little below the internal os. When first examined, the surface of the tumor was of a deep, livid, blue color; when removed three days later, this appearance was intensified. On section of the tumor, it presented the usual appearances of intersecting trabeculæ of condensed areolar tissue, with interspaces, which were filled with recently effused undecolorized blood-clots. The patient is the mother of several children, and several years past the menopause. For the first five years after the menopause she suffered from symptoms of prolapsus uteri. She then remained well and entirely free from symptoms till last summer, during which she had a long attack of a fever of remittent type, accompanied with leucorrhœa and profuse night sweats, which exhausted her very much. For some months previous to the removal of the growth she suffered from aching in the lumbar region and occasional hemorrhages, only one of which was profuse. It was removed by Thomas' serrated scoop, with a view of reducing to a minimum the by no means great danger of hemorrhage. No bleeding followed. The recovery was speedy and perfect, except for the sacral pain, which is still present. The specimen is of interest from its unusual size (not rarity) for a polypus of its kind growing in this situation. Dr. Gardner had removed a good many polypi of this kind, but never saw one so large as the one in question. Gusserow gives the size as varying from a pea to a walnut. It possessed some medico-legal interest, as when removed it presented appearances whereby, if spontaneously expelled, it might have been mistaken by a careless or ignorant observer for the products of conception, and so abortion have been suspected.

5. *Malignant Disease of the Uterus*.—This specimen con-

sisted of the uterus and appendages matted together by the products of pelvic peritonitis and cellulitis. There was a quantity of pus in the pelvic cavity, and recent lymph in the abdominal peritoneum. The depth of the uterus was reduced to 1½ inches ; its wall at the fundus thick. The vagina, in its upper part, ulcerated. The Fallopian tubes were dilated, and contained pus. The ovaries engaged in a mass of exudation. Pockets of pus in the cellular tissue, between the layers of the broad ligaments. The patient, a domestic servant, unmarried, aged 35, had consulted Dr. Gardner first in January, 1882, for continuous bleeding from the vagina for nearly six months previous. The vaginal portion of the cervix, as well as its cavity, were found covered with soft, spongy tissue, bleeding easily. It was decided to remove as much as possible of the diseased tissue. Scissors and curette were freely used. It was found that the diseased action had extended to the uterine cavity. The curette, applied to the fundus and walls, brought away a large quantity of tissue similar to that on the cervix. Fuming nitric acid was then freely applied to the whole surface. Patient recovered from effects of the operation without a bad symptom, and for some months gained strength, but the disease returned, and three months after the first curetting it was repeated, with the result of producing another short respite from the symptoms. In June she began to suffer pain, and after this the disease ran a steady course to death, which occurred somewhat suddenly in the beginning of January, 1883, from acute peritonitis. After the curetting, hemorrhage was never severe, and the vaginal discharge was never fœtid.

6. *A case of Double Tubercular Pyosalpingitis*, from a patient dying of chronic pulmonary phthisis, with general tuberculosis. Both Fallopian tubes are dilated to the size of sausages and filled with pus and softened tubercle. No symptoms were known to have been referred to the pelvic region. The uterus appeared healthy. There were evidences of pelvic peritonitis.

Dr. Alloway referred to a recent operation for the removal of cancerous disease of the uterus devised by Dr. Baker of Boston, and published in the *American Journal of Obstetrics*, April,

1882. In this operation, a funnel-shaped mass is removed, having its apex at the fundus uteri and base on a level with the internal os. The actual cautery is then applied. Dr. A. spoke of the possible relation of the specimen of salpingitis exhibited to the condition known as tubal dropsy and ovarian disease, for which Mr. Lawson Tait has recently devised an operation: removing the uterine appendages for recurrent inflammations. Tait advises early operation, and reports a series of 61 cases, with only three deaths. (*Brit. Med. Jour.*, July 29th, 1882.) Dr. T. G. Thomas of New York endorses Tait's views, and reports 4 cases upon which he had operated, with 3 recoveries.

With regard to Dr. Gardner's case of cancer uteri, Dr. Trenholme remarked that unless seen early, before infiltration of surrounding tissues had taken place, curetting was of doubtful value as to prolonging life. Of course in some hemorrhages or offensive discharges it would be helpful. Dr. T. said that the specimen of fibroma of the ovaries would be of much more interest if a history of the case could have been had. Their being free in the pelvis would seem to have warranted a hopeful interference for their removal, thereby probably saving the life of the patient. The other specimen of multiple fibromata, also without history, was of interest, as it showed conditions apt to be met with in daily practice. Doubtless many cases of uterine trouble were due to such a condition, and not recognized during life. He related a case under treatment, where a small fibroma pressed on the calibre of the cervical canal and rendered menstruation painful.

Dr. Gardner, in reply to the remarks from Dr. Trenholme on curetting operations in uterine cancer, said that although of no permanent benefit in this case of cancer, he would treat a similar suitable case in the same way. He did not think the operation of extirpation of the uterus, with its very large mortality, had as yet reached a settled basis. In reply to Dr. Alloway in regard to the acceptance of Lawson Tait's operation of removal of the ovaries and fallopian tubes in cases like that of the specimen presented, Dr. Gardner said that in this case he had not heard of any symptoms which would have justified interference,

but although the operation was still to some extent *sub judice*, he believed that it would be demonstrated to be the only cure for the obstinate class of cases indicated by Mr, Tait, viz., recurrent menstrual pelvic cellulitis and peritonitis, with the long list of local and reflex symptoms which usually accompany this condition.

Dr. Osler exhibited *the lungs of a horse which had died of pneumonia*, following the epidemic influenza which has been present in the city for some time ; it was a well-marked example of *red hepatization*, involving both posterior lobes.

Dr. Roddick exhibited *an oxalate of lime calculus, weighing nine drachms*, which he had removed that day from a patient, a young man, who had suffered with symptoms of stone for fifteen years. It was easily recognized, and from its size and hardness its removal by lithotomy was decided upon. The usual lateral operation was performed, and the calculus delivered entire with comparative ease, the forceps slipping once during the operation.

Dr. Mills read a paper on " Tonsillotomy and Uvulotomy." It appears among our original communications.

Dr. Campbell said it was his custom formerly to leave what would have been as much as an ordinary-sized uvula, but he found the subsequent retraction so great that he now only removes the tip, and finds that quite sufficient in most cases.

Dr. Osler said that many cases of pigeon-breast now existing might have been obviated if the condition of their upper pharynges had been properly attended to in early life.

RIDEAU AND BATHURST MEDICAL ASSOCIATION.

The semi-annual meeting of this Association was held at Ottawa, on Wednesday, Jan. 17. There were present Drs. Cranston (President), Arnprior ; Baird, Packenham ; McFarlane, Almonte ; Groves, Carp ; Scott, Hazledean ; Stevenson, Chelsea ; Fraser and Wallace, Metcalf ; Bell and Wilson, New Edinburgh ; and Drs. Hill, Sweetland, Grant, S. Wright, Robillard, McDougall, Church, Malloch, Bentley, H. P. Wright, Powell, Horsey, Mark, Cousins, Baptie, Henderson, Prevost, Small (Secretary), of Ottawa.

The morning was spent in the wards of the city hospitals, where special preparations had been made to render a visit interesting and profitable to the profession. In the afternoon the members assembled in the City Hall. The meeting was opened by an address from the President; after congratulating the Association upon the interest shown by its members, and reviewing the changes in the division, he concluded with some very practical and valuable remarks upon the results of the treatment of fractures.

A discussion upon Public Health was opened by Dr. Sweetland, who dwelt at some length upon the work begun in Ontario, eulogizing the system, and moved the following resolution—which was carried unanimously—

"That this Association approves of the step taken by the Ontario Government in the formation of the Provincial Board of Health, and will co-operate in promoting the object it has in view." Dr. Robillard, in seconding the resolution, spoke hopefully of the results likely to be accomplished.

The following papers were then read, each provoking a lengthy discussion: Pleural Effusions, Dr. Grant; Hæmaturia, Dr. Baird; Counter-Irritation, Dr. Horsey. Dr. McFarlane reported a case of twin birth where the cord was doubly knotted, exhibiting the preparation.

Arnprior was selected as the place for the summer meeting, to be held in June.

In the evening the city members entertained their rural brethren at the "Royal Exchange," where three hours of social intercourse terminated a most successful meeting of the Association.

MEDICO-CHIRURGICAL SOCIETY OF WINNIPEG.

In response to a circular issued by Dr. Whiteford, a number of medical men met at the Potter House on Saturday evening for the purpose of forming a medical society in this city. The following gentlemen were present: Drs. Codd, Thibodo, Patterson, Munroe, McAdam, Blanchard, Minaker, Sutherland, Jackes, Brett, Seymour, Covernton, Turnbull, Jones, Kerr, Grey, Jamieson, McEachran, Mewburn, Phillips, Ferguson, A. H.,

McDiarmid and Whiteford. Dr. Codd occupied the chair, and Dr. Mewburn acted as Secretary.

Moved by Dr. Jackes, seconded by Dr. Brett, that this meeting resolve itself into a society, to be named the "Medico-Chirurgical Society of Winnipeg." Carried.

Moved by Dr. Phillips, seconded by Dr. Seymour, that each officer of the Society be elected separately. Carried.

Moved by Dr. Phillips, seconded by Dr. Whiteford, that Dr. Lynch be President. Carried.

Moved by Dr. Patterson, seconded by Dr. Jackes, that Dr. Whiteford be First Vice-President. Carried.

Moved by Dr. Kerr, seconded by Dr. Munroe, that Dr. Codd be Second Vice-President. Carried.

Moved by Dr. Whiteford, seconded by Dr. Brett, that Dr. Covernton be appointed Secretary-Treasurer. Carried.

Moved by Dr. Whiteford, seconded by Dr. Sutherland, that the following gentlemen constitute the Council: Drs. O'Donnell, Patterson, Jackes, Brett, Phillips and Kerr.

At this stage of the proceedings, Dr. Whiteford, First Vice-President, in the absence of the President elect, Dr. Lynch, took the chair. He thanked the members present for the honour they had done him in electing him First Vice-President, and was glad to see such a large number present at the first meeting, which augured well for the future of the Society. He was glad to feel that his efforts in getting the medical men together had met with such a hearty response, and he hoped that in 1884 the Canada Medical Association, sending delegates from all parts of the Dominion, would meet in Winnipeg. He had been informed that it was the intention to do so, and it was pleasing to think that there would be a medical society to receive them. He suggested that the rules and regulations of other similar societies be obtained and submitted to the Committee, and that a meeting be called at an early date to discuss them.

Dr. Jackes suggested that the meetings be called twice a month, but the majority present seemed in favour of meeting once a month for the present.

After mutual congratulations at the success of the meeting, the members adjourned.—*Winnipeg Free Press.*

CANADA

Medical and Surgical Journal.

MONTREAL, MARCH, 1883.

WANTED—A NEW ANATOMY ACT.

During the present Winter Session, hardly a week has passed without some body-snatching case being reported in the newspapers. In former years, although, probably quite as many bodies were snatched, the work was more skillfully done and fewer scandals came to light. The reckless way that, during this winter, vaults have been broken into and graves rifled of their contents, has given rise to a considerable amount of popular resentment and a demand for more stringent measures for the detection of the culprits on the one hand and a more efficient carrying out of the Anatomy Act on the other. Practically, the present act, with its numerous amendments, has always been inoperative, simply because no penalty for non-compliance with its provisions, is attached to it. As far as we know, one institution only, has complied with the law as laid down in the Anatomy Act. The Coroner has seldom, if ever, to our knowledge, given a subject to the schools, but on the contrary, has had the friendless bodies coming under his jurisdiction, buried at the public expense and this has been going on for years. We are informed that the authorities of the Lunatic Asylum at Longue Pointe have been burying yearly, thirty or forty unclaimed bodies of friendless patients dying there. And why? Is it because it pays better to get ten or twelve dollars for burying a body than to notify the Inspector of Anatomy and get nothing? The law requires that every student before graduation should do a certain amount of dissecting and yet does not provide the material to dissect. Body-snatching will continue as long as the act is not enforced.

It is satisfactory to learn that the Local Government has taken up this matter, and, it is said, are thoroughly in earnest in their intention to make suitable provision for the wants of students. The following are the resolutions which have been introduced by the Premier, Hon. Mr. Mousseau, and which will form the basis of the expected bill. The exact provisions of the Act will be looked for with some interest:—

Resolved,—That for the purposes of the study of anatomy, the Province of Quebec be divided into two sections, which shall be known as "Quebec Section" and the "Montreal Section," which sections shall respectively comprise such judicial districts as the Lieutenant-Governor-in-Council may be pleased to specify, and that it shall be lawful for the Lieutenant-Governor-in-Council to appoint during pleasure an Inspector of Anatomy for each of such sections, and a sub-Inspector of Anatomy of judicial districts, except those of Quebec and Montreal, in which the office will be filled by the Inspectors of Anatomy; but persons so appointed shall not in any way be connected with any University or School of Medicine, or be practising physicians.

Resolved,—That every University or School of Medicine shall pay to the Inspector of Anatomy, in addition to the cost of transport and of burial, a sum of $10 for every corpse delivered, and the Inspector shall pay to the Sub-Inspector for every corpse which the latter shall deliver to him the sum of $5 over and above the cost of transport.

Resolved,—That every superintendent or director of a public institution receiving a grant from Government, and every coroner who shall knowingly omit, or who shall neglect or refuse to comply with the provisions of the Act to be based on these resolutions, and every University or School of Medicine which shall receive corpses in its dissecting room, or allow dissecting within its establishment of corpses which have not been supplied to it by the Inspectors of Anatomy, shall, upon a complaint to that effect before a Justice of the Peace by the Inspector or Sub-Inspector of Anatomy, be liable to a penalty of not less than $100, or more than $200, for each offence, and the amount of such penalty and costs of suit shall be retained by the Treasurer of the Province out of the next grant which such Institution, University or School of Medicine is to receive, or shall be retained from the emoluments which may become payable to such coroner, as the case may be.

THE ELECTION OF OUR PROVINCIAL BOARD.

On the occasion of the last Triennial meeting of the College of Physicians and Surgeons of this Province, we took occasion to draw attention to the method of election of the Provincial Board. A certain number of the members of the Board are independent of election, holding their seats as representatives

of the various teaching bodies. But the remainder are chosen by the votes of those present (personal or by proxy) at the Triennial meeting. Provision has been made by the Act for the representation of the several districts of the Province thus far, that so many physicians from such and such cities and districts must be elected. Real representation, however, is not provided for, because every member has a vote for every representative from every district. With as much truth would it be called representation, if every political vote in the Province had a vote for every member of the Local Parliament from every electoral division. No such incongruity is thought of in our political system, and of course could not be tolerated for a moment. The voters of each section of the country elect their own representative or representatives. They are supposed to be able to choose from amongst themselves the person whom they consider best fitted to attend to their interests, and whose views are in consonance with those of the majority in matters of public moment. Why should any different principle be adopted in selecting a Board which, during three years, shall govern all matters medical in the territory under their jurisdiction? Why should we of Montreal, and the country parts, help to decide the best men to represent the City of Quebec? or why should Trifluvians have a say in the representation of the Gaspé district? As it is, it is quite plain that the voting is carried on in the blindest way imaginable. Take *e.g.* a medical man from the City of Montreal attending the Triennial meeting. He is supposed to fill in a paper with the names of suitable representatives from all the country parts. It is a chance if he knows the name, standing, or local reputation of one single man in any of these rural districts, and yet he votes. He simply gets, through some of his friends, names which they may have heard mentioned as candidates. Is it to be expected that, on this system, there is the slightest chance of an intelligent selection being made of the most capable men to whom we shall intrust such highly important interests?

We believe that at the last election the majority of the voters appeared to govern themselves, as well as they could, by what

seemed to be the desire of the profession in any given locality with reference to their representative; and the result was the selection of a Board to which no exception has been taken. We do not, therefore, wish in the slightest degree to detract from the efficiency of the present, soon expiring Board. But it is quite possible that, under other circumstances, the result would not be at all so satisfactory. It is quite conceivable that an excellent representative who was strongly supported by those of his own district (who certainly ought to be best able to judge) might lose his election by means of factious opposition on the part of opponents, easily worked up amongst the outside men. At any rate, the principle appears to us absurd and indefensible, and we have never heard any good reason given why it should continue in operation, instead of our having territorial representatives by local election, as is done in Ontario and elsewhere. As the Triennial meeting will soon again take place, we should be glad to know that this matter was receiving some consideration.

MEDICAL MEN IN PARLIAMENT.

Canada is fortunate in having a large number of doctors both in the Dominion and Local Legislatures, as now-a-days many questions arise involving, directly or indirectly, the interests of science and public health, questions upon which the special knowledge of medical men may be of great value. Compared with other countries, the representation of the profession is here unusually large. England, with over twenty thousand practitioners, has not a single medical man in the House of Commons; Ireland has but two, and Scotland only three. We have been at some trouble to get reliable returns from the different Provinces, and have given after each name the college or school and the year of graduation:—

DOMINION PARLIAMENT.

Senate.—Pierre Baillargeon (Harvard, '40), Quebec; Anselme H. Paquet (Sch. of Med., Montreal, '53), St. Cuthbert; C. E. Boucher De Boucherville (McGill, '43), Quebec; William J. Almon (Glasgow, '38), Halifax; Thomas R. McInnes (Rush, '69), New Westminster; John Schultz (Vict., '64), Winnipeg; Louis Robitaille (McGill, '60), New Carlisle, Q.—7.

Commons.—Derby Bergin (McGill, '47), Cornwall, O.; J. G. Blanchet, late Speaker, (Prov. Lic., '50), Levis, Q.; Hugh Cameron (Univ. Penn., '61), Mabou, N.S.; Louis L. L. Desaulniers (Harvard, '46), Montreal; J. E. A. De St. Georges (Schl. of Med., Montreal, '—), Portneuf, Q.; Charles F. Ferguson (Queen's, '59), Kemptville, O.; John Ferguson (Vic., '64), Welland, O.; James F. Forbes (Univ. of N.Y., '42), Liverpool, N.S.; John T. Jenkins (F.R.C.S., Eng.), Charlottetown, P.E.I.; John M. Platt (Vic., '69), Picton, O.; Pierre Fortin (McGill, '45), Gaspe, Q.; Paul E. Grandbois (Laval, '69), Riviere du Loup (*en bas*) Q.; Chas. A. Lesage (Laval, '—), St. Claire, Q.; Chas. E. Hickey, (McGill, '66), Morrisburg, O.; Geo. Landerkin (Vict., '62), Hanover, O.; Peter A. McIntyre (McGill, '67), Souris, P.E.I.; George T. Orton (St. Andrew's, '60), Fergus, O.; Côme J. Rinfret (Sch. of Med., Montreal, '70), St. Croix, Q.; James E. Robertson (McGill, '65), Montague, P.E.I.; Louis Springer, Hamilton, O.; Thomas S. Sproule (Vict., '68) Markdale, O.; Sir Chas. Tupper (Edin, '43), Ottawa; John H. Wilson (Vict., '58), St. Thomas, O.—23.

QUEBEC.

Lieutenant Governor.—L. T. Robitaille, (McGill, '58).

Legislative Council.—C, B. de Boucherville, (McGill, '43), Quebec; John J. Ross, (Sch. of Med., Montreal, '53), Quebec.—2.

Legislative Assembly.—Louis Duhamel (McGill, '66), Wight, Q.; Edouard Laberge (McGill, '56), Ste. Philomene; Alex. Cameron (Glasgow, '63); V. P. Lavalée (Sch. of Med., Montreal, '60), St. Felix de Valois; Isidore Frégrau, (Sch. of Med., Mont., '61), Stukely; D. Martel, (Sch. of Med., Mont., '65), Chambly; H. J. Martin, (Laval, '68), Carleton; R. Rinfret, (Harvard, '45), Quebec.—8.

ONTARIO.

Chas. H. Brereton (Vict. '68), Bethany; Jacob Baxter (Univ. N.Y., '54), Cayuga; John Cascaden, (Univ. Toronto, '63), Iona; John F. Dowling, (McGill, '75), Eganville, Co. Renfrew; James W. McLaughlin, (Univ. Toronto, '64), Bowmanville; James McMahon, (Univ. College, Toronto, '50), Dundas; Robt. H. Preston, (Queen's, '64), Newboro; J. Henry Widdifield, (Victoria, '69), Newmarket.—8.

NOVA SCOTIA.

Legislative Council.—D. McNeill Parker, (Edin., '45). Halifax.

Legislative Assembly.—C. H. Munro, (Harvard, '63), West River, Picton; Duncan Campbell (Harvard, '69), Port Hood, N.S.; Angus McLennan (Univ. Penn., '73), Margaree, N.S.—3.

PRINCE EDWARD ISLAND.

Legislative Council.—James Fraser, (Harvard, '71), St. Peter's Bay.

Legislative Assembly.—Peter McLaren, (McGill, '69), New Perth, P.E.I.; John A. F. Gillis, (McGill, '77), Summerside, P.E.I.—2.

NEW BRUNSWICK.

W. J. Lewis, (Glasgow, '55), Hilsboro; E. A. Vail, (Glasgow, '37), Sussex; Chas. A. Black (Univ. Penn., '59), Baie Verte.—3.

MANITOBA.

D. H. Wilson, (Toronto, '78), Nelsonville.

There are in all sixty members of the profession in the Legislatures—thirty in the Dominion House and thirty in the Local Assemblies. Distributed according to Schools and Colleges, there are from McGill, 13; Victoria, 8; Harvard, 6; School of Medicine, Montreal, 6; Univ. Toronto, 4; Glasgow, 4; Univ. Pennsylvania, 3; Laval, Edinburgh, Queen's (Kingston), Univ. of New York, each 2; Royal College of Surgeons, St. Andrews, Rush, each 1.

Medical School for Women.—It is reported that a School of Medicine for Women is about to be established in Toronto. While not opposed, in certain instances, to lady doctors, we are strongly of opinion that no such institution is needed in this country; the demand does not yet exist to such an extent as to warrant the necessary outlay for a proper establishment. It is said that any Canadian woman wishing to enter the profession, cannot do so by studying in American colleges, as the prominent boards demand a year's additional study in the case of American graduates, but we feel sure that if, after passing the matriculation, four years were spent in study at one of the *reputable* American schools for women, the Licensing Board would be quite safe in admitting them to examination. We predict for the School of Medicine for Women, started under the present circumstances of the country, a wretched and brief existence.

Licenced Quacks.—We are often asked how it is that in Ontario quacks of all kinds seem to flourish in spite of the penal clauses of the College of Physicians and Surgeons. The papers teem with advertisements of institutes of various kinds, and Medical and Surgical associations, many of them with headquarters in the States, and travelling agents in this country. The reason is that the organizers and proprietors of these establishments have either themselves come "within the fold" by qualifying before the Council, or have duly qualified assist-

ants. The notorious Drs. K. and K., of Detroit, have a special staff for Ontario, and take good care to send only those whose names are on the register. They get men easily enough; the profession is not without members "so base and full of wretchedness" that their poverty, when not their wills, makes them consent to be participators in these concerns.

Public Vaccination.—It has been found by comparison of the birth-records with the reports of the public vaccinators in this city, that a considerable number of infants fail to be vaccinated, at any rate, within the specified time of three months. A meeting of these officials has lately been held at which this matter was discussed and it was maintained that further provision should be made for ensuring the vaccination of every infant registered within the city limits. A report to this effect was adopted and will be laid before the Board of Health.

Medical Statistical Officer.—Dr. A. B. LaRocque, medical health officer of Montreal, has received a communication from the Minister of Agriculture to the effect that he has been appointed by the Governor General in Council, statistical officer for the collection of mortuary statistics for the city of Montreal, under the rules and forms of the department of agriculture, respecting the collection of mortuary statistics approved by the Governor General in Council on the 26th of December last. A full supply of the necessary forms has also been forwarded. Dr. LaRocque will enter upon his duties at once.

McGill College Examinations.—The Spring Matriculation Examination of the Medical Faculty, McGill College, will be held in the High School on Friday and Saturday the 30th and 31st of March. Primary Examinations begin on Monday the 19th, and the Final on the 22nd. Convocation will be held on Saturday the 31st, at 3 p.m., in the Molson Hall. We hope to see a full turn out of the graduates from the city and neighbourhood.

—We have received from Dr. Hingston, of this city, a "Note-book for Cases of Ovarian and other Abdominal Tumors," which he has recently had prepared, and which can be obtained from

the publishers. The arrangement is mainly that followed in the similar books of Mr. Spencer Wells and Dr. Hodges; but Dr. Hingston has also made some additions and alterations under the heading of diagnosis, which his experience has led him to believe will assist in the prevention of errors. It contains also diagrammatic charts for noting the exact location, etc, of tumors. A schedule of this kind is no doubt highly useful, and should be in the hands of every one having to undertake the diagnosis of these important cases.

—We have received an early number of *The Planet*, the last claimant for the attention of the medical world—this time from New York. *The Planet* follows no beaten track, as well-behaved planets should. It is "all original," no effete matter from other journals to clog it in its onward flight, and, better still, "no rejections." Ho! all ye who, affected with *cacoethes scribendi*, have had your long-drawn articles returned with thanks by unfeeling editors: here is one who will not treat you thus. We are not impressed with the editorial matter of this number of *The Planet*, and predict that, if not improved upon, it will never hold a place in a centre of learning like New York. Besides, the tone of some of its remarks is certainly not commendable, *e.g.*, with reference to the death of Gambetta, it is seriously contended that he died of a bullet wound of the abdomen and it is insinuated that the public report was hocussed. Is this decent on the part of a medical periodical when we know that the autopsy was made by no less a person than the well-known Prof. Cornil, and vouched for by Profs. Charcot, Verneuil, Filat, and Bronardil?—a tinge of modesty would become *The Planet*.

—The number of the *New York Medical Journal* for 24th of February will be found one of great interest to the number of men about to graduate at this season. It is called the "College Commencement Number," and contains a series of articles upon the New York Hospitals, and the arrangements for their resident staffs; very interesting editorials specially devoted to the interests of the recent graduate; an article by Prof. St. John Roosa, upon the opportunities for the study of medicine in New

York City after graduation; and letters from Washington, Philadelphia, Baltimore, Boston and St. Louis concerning matters connected with medical education.

—The Toronto City Council has decided to appoint a Health Officer for the city, with a salary of $1,500 a year. From the discussion which took place at the meeting, many of the aldermen appeared to know very little of the duties of such an important officer, and wished him burdened with the professional care of the city poor and the goal. Dr. Canniff's name is mentioned in connection with the appointment, and if he can be secured, the Queen City may be congratulated, as he is one of the few medical men in the country who has given proper attention to public health matters.

—From the advertisements in the Toronto journals, one learns that the Ontario Council Final Examinations will be held in Toronto and Kingston on Tuesday, April 3rd. The Primary Examinations will take place in Kingston on Friday the 13th, and Toronto on Monday the 15th.

Obituary.

Professor Croft, Toronto University.—Though not a member of the medical profession, Dr. Croft was, in many ways, connected with it. The medical students of Toronto School of Medicine had for many years the privilege of attending his lectures, and during his long career the profession of Ontario looked to him for assistance in all matters requiring a chemical expert. For 35 years he filled tae Chemistry Chair in University College, and his exertions during that long period conduced largely to the prosperity of that Institution. Though a young man when appointed to the Chair, he had received a very thorough training in England and in Germany, and brought to his work an enthusiasm which did not wax old with years, and which made him a great favorite with the undergraduates. His death took place from heart disease, at Texas, on his son's ranch, to which he retired after his superannuation two years ago.

Arthur Moren, M.D., (Edin.)—Many of our readers will hear with deep regret of the death of Dr. Moren, of Halifax, the City Health Officer. He had been in ill-health for some time, and had had hemorrhage from the stomach. The attack to which he succumbed came on suddenly on the 27th ult. He

was a native of Halifax, and a graduate of Edinburgh University (1860).

W. D. Ross, M.D. (McGill).—We regret to see reported the death of this gentleman, at Pembina, Da., from diphtheria. He was the son of Judge Ross of Ottawa, studied medicine at McGill, and graduated in 1875. He had been in practice in Pembina several years, and was very successful.

Personal.

A son of Dr. Oliver Wendell Holmes has been made a Judge,

W. D. Montgomery, M.B. (Toronto), has passed the M.R.C.S., England.

Dr. Kennedy, who has been ill for several weeks, is now convalescent.

H. A. Higginson, M.D. (McGill, '80), of Portage-la-Prairie, Man., has left for Europe.

Dr. Augustus C. Hamlin, of Bangor, Me., has been appointed Surgeon-General of the State.

Duncan A. Carmichael, M.D. (McGill, '73), Assist.-Surgeon Marine Hospital Service, is stationed at Pittsburg, Pa.

We regret to see that Dr. Jenkins, of Prince Edward Island, has been unseated by the Supreme Court.

S. R. Rogers, M.B. (Toronto), and W. H. Macdonald, M.D. (Trinity), have received the double qualification of Edinburgh.

Dr. Kollmeyer has been ill for some time, and unable to attend to his duties. We regret to hear that he is not any better.

Dr. Buller has completely recovered from an attack of rheumatism which had confined him to the house for several weeks.

H. H. Gardner, M.D. (McGill, '78), who has been practising for several years with great success at West Lynn, Man., has moved to San Francisco.

Dr. Sommer, formerly German pastor in this city, and a graduate in medicine of Wurzburg, is editing the Listowel (Ont.) *Volksfreund*. The paper shows evidence of the Doctor's well known literary ability, and his many friends in the profession here will be glad to hear of his success.

W. J. Neilson, M.D. (McGill, '78), has been appointed Health Officer at Winnipeg, with a salary of $1200 a year. We feel sure, from our knowledge of Dr. Neilson and his abilities, that he will give great satisfaction in the performance of his important duties.

T. W. Mills, M.A. (Toronto), M.D. (McGill, '78), has been appointed Demonstrator of Physiology and Histology in the Medical Faculty of McGill College. Since his return from University College Laboratory, Dr. Mills has acted as assistant to Professor Osler during the past two sessions, and has conducted the most thorough and systematic course in Practical Physiology ever given at a Canadian school. The papers and practical examinations for the Morrice Scholarship in Physiology shew the nature of the training in this important branch. Dr. Mills left on the 14th for an extended course of study in the laboratories of Strasburg and Leipzig on Experimental Physiology and Physiological Chemistry in relation to general Medicine.

Medical Items.

—The Integrity Medical Aid Fund of Toronto, referred to in our last, has collapsed.

—The committee of the American Medical Association, appointed to arrange for the publication of an Association journal, have recommended the undertaking.

—We hear that the Kingston lady students are to have a separate examination in the spring, and their standing not to be ranked with the males. A special prize will be offered for those going up for the final examination.

What's in a Name.—A learned professor in one of our Canadian Colleges Engineering Department, saw advertised a work on "Cuttings." Believing it to be just the one he wanted, it was ordered, and on arrival, judge of his horror!—the volumes were full of *patterns of underclothing*,. It is said that the professor has arranged with the librarian not to shelve the work.

—*Science* is the name of a new American weekly, issued at Cambridge by Moses King. It aims to be to American science what *Nature* is to British, and from the eminent names on the staff, we have no doubt that it will be equally successful. The editor is Mr. Scudder, of Harvard. To any of our readers who wish to be kept posted in recent scientific matters we can heartily recommend it.

Cooper Medical College.—The Medical College of the Pacific, established in 1859 by Dr. Elias T. Cooper, has had the magnificent donation of a college building, costing about one hundred thousand dollars. The donor is Dr. Lane, a nephew of the founder, and the only condition of the gift has been the change of name to the "Cooper Medical College." A full three years course has been established, and all the requisites furnished

for conducting a first-class institution. We have received a copy of the addresses delivered on the occasion of the formal opening of the school. That of Prof. Lane indicates that he had laid to heart Sir Thomas Browne's precept, "If thy riches increase, let thy mind keep pace with them."

—The Chicago correspondent of the *Medical News* gives the particulars of a pending lawsuit which exposes the *two session* system of many American Colleges. Three students, who had been attending the spring course at Rush, entered the College of Physicans and Surgeons with the hope of graduating at the end of the winter term, the hope based, they affirm, on a promise from the Faculty. The arrangement has been cancelled by the Faculty, and one of the students has entered an action against the College. Doubtless a number of students economize time by attending two sessions in one year, the arrangement of classes at many of the Colleges being specially adapted for the purpose. A certificate of a year's study with a doctor and two sessions qualifies a student at the majority of the American schools, and an instance of the way in which this works came to our notice a few years ago. A young man from the State of New York registered in the summer session of McGill Medical Faculty, which is an optional three months course. He had not studied with a physician, but had been engaged in teaching school. At the conclusion of the session he received the certificate of attendance. The following October he entered a medical school in one of the large American cities—a member, we believe, of the "Association of American Medical Colleges"—and graduated from the same by the first of March, about eleven months from the commencement of his studies. He had attended two sessions, and the doctor's certificate was not hard to produce.

The Universal Stomach Pump and Enema Syringe.—We have received one of the above instruments from Mr. F. Gross, instrument maker, 688 Craig Street. It is manufactured by him from a recently-patented improvement. Its advantages consist in its very flexible and durable tube, its simplicity, and the readiness with which it can be employed even by persons without much skill. The fact that the same instrument can also be used for the administration of enemata, or for washing out cavities, &c., will further recommend it to physicians. We can speak highly in its favor.

The Portable Electric Light.—At last we can have the electric light where it can do the most good. That is to say, we can put it now on our desks, on our tables, on our mantel-pieces, anywhere, in fact, where a clear, bright, safe light is wanted. The Portable Electric Lighter, patented in 1879 and again in 1882, is now before us, and we look at it with surprise and happiness. Surprise, because it is evident how great a progress we have made in the science of electricity; happiness, because it gives us a clearer, better, more movable light than any we have ever enjoyed. Here is a lamp, so called, occupying only the space of five square inches, which can be carried anywhere, and is, besides, an ornament. By simply pressing upon the knob to the full extent of the spring (which connects with the battery), an electric current is produced by which the spiral of platinum is heated to incandescence, and the light is instantaneous. The material lasts about two months, and can be renewed at a small cost through any chemist. It will not be long before everybody will have a portable electric lighter. The price ($5) is so low that it cannot fail to become popular at once. The principal office is at 22 Water Street, Boston, where all applications for this most novel lamp should be sent.—*New York Real Estate Chronicle*, Dec. 16, 1882.

CANADA

MEDICAL & SURGICAL JOURNAL

APRIL, 1883.

Original Communications.

VIENNA LETTER.

NERVOUS DISEASES—SPINA ON TUBERCLE BACILLUS.

(*From our Special Correspondent.*)

VIENNA, March 12, 1883.

Diseases of the Nervous System.—There is probably no department of medicine better taught in Vienna than the nervous system. The material for teaching is abundant, and, what is much more important, the teachers are able, thorough, and hard-working men. In any large city, material for clinical purposes in this, or, in fact, in any special department of medicine, is sufficiently plentiful, if only men can be found who are both able and willing to make use of it. There are courses here on the coarse and minute anatomy of the nervous system by Professors Meynert and Exner, on the experimental physiology by Prof. Obersteiner, and on the pathology of the central nervous system by Prof. Stricker. Professors Meynert, Rosenthal, Benedikt, and docent Weiss have each their daily kliniks, at which they give clinical demonstrations of nervous cases. Prof. Nothnagel, who is the director of one of the general medical kliniks, directs special attention to nervous cases. Prof. Meynert is the director of what is called the "observation wards." Cases of epilepsy, hysteria, delirium tremens and "borderland cases" are under his charge. He also oversees and gives special instruction to those who want to work at the finer anatomy of the brain, a department he has done much to clear up by a long series of very patient and laborious investigations. Prof. Benedikt, who

has for many years occupied a prominent position in the scientific world, is still a very hard worker. Besides his daily klinik, he conducts a course on what he calls craniography. Professor Rosenthal is well known to your readers as the author of an excellent little work on the nervous system, which appeared in Wood's Medical Library. Although an old man, he still works away at his cases with great vigor.

The Causes and Treatment of Locomotor Ataxia.—Locomotor ataxia is by far the most frequent of all the chronic diseases of the spinal cord. In spite of its pronounced symptoms, it is very frequently mistaken for something else. It is often called rheumatism, "flying neuralgia," paralysis, or "disease of the spinal cord." There is not a week but one sees in some of the kliniks a case of locomotor ataxia that has generally been called something else, and what happens here happens also in Canada. This is not a matter of indifference, as some "practical physicians" may think, but one of vast importance. The opinion is steadily gaining ground that locomotor ataxia is, at least in its earliest stages, a curable disease. Erb and Weiss are both convinced that the early treatment of this disease will, in the near future, be generally practised. At present, this is not usually done, for when the diagnosis of locomotor ataxia is made, the patient is usually told that he has an incurable disease. Prof. Benedikt has stretched both sciatics for not only the relief of the pain in locomotor ataxia, but also for the cure of this disease. The latter object he, however, has never attained, and he has come at last to the conclusion that it is not attainable by these means. He showed recently a woman whose sciatics were stretched over a year ago, with the effect of not only banishing the pains, but also of greatly benefiting the trouble in other respects. The patellar reflex, which was absent before, returned after the operation, and she ceased to suffer from the paresis of her bladder and rectum also after the stretching. She was also able to walk round much better. Lately, however, the ataxia, bladder and rectum paresis, as well as the loss of the knee reflex, have returned, and are all, in fact, more pronounced than they were previous to the operative interference. He con-

siders, however, that the stretching of the sciatics and crurals will always remain one of our most valuable means in relieving patients from the terrible pains which are often present in this disease.

As to the cause of locomotor ataxia, it is well known that Erb, Gowers and others have recently published statistics which showed that in about 50 per cent of cases there was a distinct history of syphilis. Weiss of Vienna, who has carefully examined over 100 cases, could only find a syphilitic history in about 10 per cent—a per centage not higher than could be found in 100 healthy persons. Weiss maintains that exposure to wet and cold is the great cause of tabes dorsalis. After the short campaign of 1866, there were many cases of locomotor ataxia in the Austrian army. In one regiment, as many as ten cases occurred. This is attributed to the fact that they suffered great privations from lying night after night on the wet ground. It would be very instructive if the statistics of the Canadian cases could be collected. The writer is of the opinion that it would be found that raftsmen would head the list. If syphilis was a direct cause of locomotor ataxia, we would expect some benefit from anti-syphilitic treatment. It has, however, been shown that neither mercury nor iodide of potassium have any beneficial influence over it.

In Vienna, electricity is considered to be the best means we at present possess in retarding the progress of this disease. It is even asserted by a few that a cure is at times possible. The direct application of the galvanic current to the spinal cord is the method usually employed; one pole being applied to the nape of the neck, and the other over the spine, in the lumbar region. Strong currents of long duration should be avoided. Daily sittings of from 3 to 5 minutes' duration are recommended by both Benedikt and Weiss. To treat this, or, in fact, any other disease, by electricity in a scientific manner, it is absolutely necessary that the physician should make use of a good galvanometer. Different persons possess greatly different powers of resistance to the electrical current, and it is only by employing the galvanometer that this resistance can be measured. At the

meeting of the International Electrical Congress last summer it was decided to use a new form of galvanometer. This instrument, which is made by Dr. Edelmann of Munich, has been in use here for three weeks. It is found to be very sensitive, and it possesses a still further advantage over the older forms, in the fact that when the needle is deflected it immediately comes to rest, and does not oscillate for a minute or more. It is called a *Milliampère*. In future, in reporting the electrical condition of muscles or nerves, the expression, "it took 10, 20 or 30 milliampères to bring out a contraction," will have to be used, and not that "5, 15 or 20 cells were used." In some people 5 cells will deflect the needle more milliampères than 20 cells in others.

The faradic brush is recommended highly by some German physicians in locomotor ataxia. Rumpf of Bonn reports two cases of at least temporary cure by this means.

In addition to exerting a beneficial influence over the general state of ataxics, galvanism is useful to relieve some of the most annoying symptoms that these patients suffer from. The lightning pains are often subdued when one pole (the positive) is placed over the spinal column and the other over the painful spots. The bladder and rectum troubles can also be relieved by the same means.

The internal use of nitrate of silver is still believed in here as a means of retarding, in many cases, the progress, and, in a very few cases, of actually curing, locomotor ataxia.

The controversy which has been going on during the last five years between Westphal and Erb as to the nature of the "knee phenomenon" has at last apparently been settled. Westphal has always maintained that it was a "local phenomenon," a muscle tonus. Erb, on the other hand, contended that it was of a reflex character. Schultze and Furbinger's experiments have proved that it is a true tendon reflex. That the absence of the patellar reflex is not always to be relied on as a diagnostic symptom of tabes dorsalis is proven by the fact that it is absent in about 2 per cent. of healthy people. Neither, as the following case shows, does its increase prove the absence of tabes. A man,

aged 25, with a good family and previous history, began to complain two years ago of giddiness and headache. Shortly afterwards both internal recti were paralyzed. His present state is as follows: There is atrophy of both optic nerves. He is impotent, and has difficulty in voiding both urine and fæces. He complains of "lightning pains" in his lower extremities. There is numbness of the feet and in the little fingers. There is no ataxia. The patellar reflex is *increased*. He has been under Weiss's care during the last two years, and is steadily growing worse. There can be no doubt about the nature of this case, despite the absence of ataxia and the presence of an increased patellar reflex.

Unilateral Paralysis of Nine Cranial Nerves.—The following remarkable case has been shown by Weiss during his present course. It has also been demonstrated before the Medical Society of this city by Prof. Bamberger. The patient is a married woman, aged 53. She has had several children. Four years ago her menses ceased. Previous and family history good. The first symptoms of her present trouble commenced in the spring of 1880, with pain in the right parietal region, extending backwards to the occiput and forwards to the temporal region of the same side. The pain, which was continuous, was worse at night. The removal of four decayed teeth from the right lower jaw was not followed by any relief. She is still troubled, although not so severely as formerly, with this pain. In the fall of 1880, paresis of the right facial and the right abducens nerves was noticed. In 1881, she had inflammation of the eye, followed by ulcers on the cornea. She first came under observation in the hospital shortly afterwards. Her present state is as follows: Examination of the thoracic and abdominal organs is negative. The motor and sensory innervation of the extremities and sphincters is normal. She is well nourished. There is complete paralysis of the right facial nerve. The reaction of degeneration which was previously present has disappeared, on account of the nerve being completely destroyed. Over the whole of the right half of the tongue there is loss of taste and common sensation, showing that the chorda tympani and glosso-

pharyngeal are likewise affected. There is complete immobility of the right eye-ball, with ptosis, proving that the third, fourth, and sixth nerves are likewise implicated. The right cornea is thickened, turbid, and adherent to the iris. The conjunctiva is injected. In spite of the turbidity of the media, she is able to count fingers, which proves that the optic nerve has escaped. An accurate ophthalmoscopic examination is not possible. The right corneal reflex is destroyed. There is diminished sensation of the right side of the face. The temporal and masseter muscles of the right side are much wasted. A tuning-fork or watch placed over the right parietal bone is heard much less distinctly than when placed in a corresponding position on the other side of the head. She, however, hears a watch placed close to the right ear better than when placed near the left ear. In spite of the latter fact, Bamberger considers that the acoustic nerve is involved. He explains the better hearing of the watch on the right side by attributing it to an extreme tension of the tympanum, brought about by the unopposed action of the tensor tympani, its antagonistic, the stapedius (a branch of the facial) being paralyzed. The right trapezius and sterno-mastoid muscles are atrophied, but not paralyzed. There is loss of sensation and motion in the right half of the larynx, showing paralysis of both the superior and inferior laryngeal nerves. These two nerves are properly branches of the spinal accessory and not of the vagus. At least this is the view now held by several eminent physicians. This case itself goes a long way to prove that this view is the correct one, seeing that the vagus otherwise is not affected. The right half of the tongue is atrophied, and the seat of fibrillary twitchings. In this case, then, it is seen that the following nine of the twelve cranial nerves are paralyzed in a greater or less degree. The third, fourth, sixth and facial are completely paralyzed. The spinal accessory and the trigeminus (sensory and motor portions) are in a high degree paretic. The glosso-pharyngeal, hypoglossus and acoustic are only slightly paretic. The olfactory, optic and vagus have escaped. As it is impossible for the morbid process in this case to have either a peripheral or cortical origin, its seat must be either in the base

or in the medulla itself. There are several reasons why the latter situation should be considered the seat of the affection. 1. A unilateral affection of the meninges at the base covering such a large area as would be necessary to involve all the nerves affected here is extremely unlikely. 2. The fact that the trophic branches of the spinal accessory have suffered, and the motor have remained free, is almost sufficient of itself to prove that the process is seated in the medulla. As to the nature of their change, Bamberger and Weiss are both of the opinion that it is similar to what takes place in bulbar paralysis.

The Tubercle Bacillus.—The interest in the tubercle bacillus question, which was lately beginning to wane, has been suddenly revived by the publication of a pamphlet in this city, having for its title "*Studien über Tuberculose.*" The author is Dr. Spina, one of the assistants in Prof. Stricker's Institute. Spina maintains that he is able to color other bacterial forms, besides those of tubercle and lepra, blue by means of Koch's or Ehrlich's method. This statement is in direct contradiction to Koch's, who says that by his method there are no known bacteria which are colored blue, except those of tubercle and lepra. Spina says that by treating putrefactive serum and blood by Koch's coloring method he has discovered bacteria which retain a blue color, and which resemble those found in the sputa of tuberculous patients so much that it is impossible to distinguish the one from the other. Spina further maintains that there is no constancy in the size of Koch's tubercle bacillus, as is maintained by the latter. He says that in a tuberculous nodule you find bacteria of different colors and sizes, and he asks, How is one to tell the pure bacillus among all these? He contends that the most careful examination of tuberculous sputa is often negative. He says that it is extremely hard to find bacilli in the tuberculous nodule of serous membranes when examined immediately after the cavity is opened, but easy when it has been exposed to the air for some hours. He concludes his work by giving an account of a few experiments where he has inoculated animals with a cultivated fluid prepared after Koch's method, and where there was no tuberculosis induced. If Spina's statements are correct, it, of course, follows

that there is nothing distinctive in the bacilli found in tuberculous sputa and infiltrations. His methods of coloring are very unfavorably criticised here. His pamphlet had not been three days issued before a paper was read in one of the medical societies by Dr. Frisch, who endeavored to show that his work was valueless. The leading pathologists do not speak very highly of it either, some of them even saying that they feel ashamed of it as a Vienna production. This week Koch himself has replied to Spina, and not in very complimentay terms either. After referring to some of his American critics (Cutter, Formad and others) in a rather contemptuous way, he says that Spina knows nothing about bacterial pathology, and that his *Studien über Tuberculose* will have no influence, one way or another, over the tubercle bacillus question. "It's only effect will be to damage the reputation of the author and the Institute where he works." Koch, in his letter, adduces no additional facts ln support of the existence of a special bacillus for tubercle. He considers none are necessary. Neither has he repeated his former experiments. Among many physicians, however, there is a feeling that Koch is far from being all right and Spina all wrong. Koch, in his letter, goes out of his way to cast a slur on Professor Stricker, because such a work was issued from his Institute, and because he does not know more about bacterial pathology. Prof. Stricker, a few days after the appearance of Spina's pamphlet, publicly stated that he had nothing to do with it either directly or indirectly. He devotes all his energy to the nervous system, and lays no claim whatever to being acquainted with the modern methods of detecting bacilli.

VALEDICTORY ADDRESS TO THE GRADUATING CLASS, 1883.

By G. P. GIRDWOOD, M.D., M.R.C.S., Eng.
Professor of Chemistry and Practical Chemistry, McGill University.

Gentlemen Graduates,—We are assembled here to-day to confer on you the degree of Doctor in Medicine and Master in Surgery, the degree to which you are entitled by the industry you have displayed in following out the curriculum laid down

by the authorities of this university for your pursuance, and the satisfactory manner in which you have acquitted yourselves in the closing exercise thereof, the examinations of the past fortnight. The medical faculty, your teachers, congratulate you on the measure of success you have achieved : a success which they hope will be only a prelude to that greater success you will obtain in years to come in the practice of the profession of your choice.

It is customary on occasions like the present to offer a few words of advice, which it is hoped may guide you in the performance of the arduous duties you now assume. The degree which has just been conferred on you is an honorable one. It derives its honor first from the profession to the practice of which it is the gateway ; for what occupation can a man find more honorable than that which has for its object the alleviation of the distress of his fellow men, the assuaging of their pain, and the restitution of their tortured bodies to health and vigor—an occupation wherein the Great Physician himself took infinite pleasure, and left an undying example for you to follow. And secondly, the degree you have just now obtained is honorable from the position of respect it holds. Throughout the world wherever a graduate hailing from McGill University presents himself he is received with respect, and his views listened to with attention. This position has only been obtained by the unwearied exertions of the professors of the different chairs keeping ever in the van, and by the conduct and labors of the graduates who have preceded you, who have performed their duty, always laboring for the good of their *Alma Mater* during the half century of her existence of which the present is the closing day. Thus in assuming this degree, and in taking its obligation you have just now sworn to, you have taken upon yourselves new and serious duties. To uphold the high position of distinction which has been acquired for the degree of your *Alma Mater* by the fifty classes of graduates who have gone forth from these halls of learning before you, and to practice your profession *caute, caste, et probe* ; in the performance of these duties you will meet with dangers, difficulties and tempta-

tions. The medical adviser is generally the friend of the family, and oftentimes family secrets are confided to his keeping, and his advice sought upon matters not simply professional. In all such cases you must be ready to listen, to give advice; it is often a great relief to tell a tale of woe to some sympathizing ear, to relieve the over-burdened breast by a confession, and no one is so often called upon to receive such confidences as the physician, and you must most sacredly respect the confidence thus bestowed upon you.

Your motto must be, "*semper paratus*," ever ready by night or day to attend the summons of the sick, for if not ready those who trust themselves to your care may lose their lives by your neglect or ignorance, and such an occurrence, the loss of a life valuable to others even indirectly caused by you, would entail upon you a life-long regret. The what to do and how to do it must be a knowledge ever present to your mind. There is no time to consult books or authorities; now, now is the golden opportunity with you, a few minutes hence the chance of doing is gone, the patient is dead. You have passed through the curriculum and examinations which the law claims from you; but that by no means ends your career of studentship, in fact you are but beginning it; you now know how to study, what to observe, and how to record it for future benefit. You must cultivate all your senses to the finest appreciation of all the points that present themselves. It is by cultivation that plants are improved, and the wild varieties made to yield the beautiful flowers we delight to see, and that plants poisonous in themselves are improved so as to yield food not injurious to man. So by cultivating your senses, you will be the better enabled to grapple with the cases committed to you by cultivating your sight; you will be able to detect new beauties in objects every day presented to your observation, to recognize substances when you see them, and determine the novelty of something you have not been accustomed to. The practice of the use of the microscope will reveal to you many facts previously hidden from your view. Your sense of smell, if cultivated, will be of great service to you; enabling you perhaps to detect some

poison that may have been taken, or the indulgence of some forbidden habit. By a refined and cultivated touch you will be able to perform the necessary examinations of a broken or diseased structure so gently as to give only the minimum of necessary suffering. You will in your practice meet with patients who whilst intending to give a truthful account of their ailments, and to tell you the whole truth about themselves, nevertheless deceive themselves and thus deceive you; or, again, you will meet with others who wilfully deceive themselves and those around them, and even try to do the same to the physician in attendance, to the formation of whose opinion of their case the truth on their part is absolutely necessary, as otherwise an opinion founded on false premises, and therefore itself erroneous, will be given; or if the patient be perfectly truthful you will find, perhaps, interested persons who surround your patient, purposely trying to throw dust in your eyes by misleading statements; you must be prepared to sift all these statements and verify them or prove their falsity, so that you may have a really sure foundation on which to base your opinion. Therefore you will find a cultivation of your powers of observation invaluable to you for finding out the physical signs of health and aberrations therefrom. Your success in life financially will depend to a large extent not simply on your talent or the correctness of your judgment, but upon the good opinion formed of you by your patients. The visit of the physician is often times looked upon by the patient as the single oasis in the miserable day desert of his sickness; your advent will be watched for with eager expectancy, and your departure be the signal for a return of the miseries of a hypochondriac. By a genial manner, a gentle voice, and a demeanor expressive of sympathy with their sufferings, real or imaginary, and oftentimes the imaginary are more serious to the patient than the real, you will win their confidence, and when they pass from your care, you will receive their thanks as well as their remuneration for your services. Too often you will find thanks your only recompense, and not unfrequently you will find both remuneration or thanks not tendered, or if given, given grudg-

ingly, and with such a bad grace it were almost as well not given at all. And even after doing your best, and that best all that any other man could do, you will find dissatisfaction expressed, and attempts to extort money from you as damages for malpraxis, because the results of your labors have not been attended with such success as your exacting patient required. Such patients you must regard as the hard task master Pharoah, and pity them that their hearts had not been fashioned in a gentler mould. By attention to your business, to the needs of your patients, and a careful scrutiny of your conduct, you can not fail to succeed. The prizes in the profession are few; but the best of all is within the reach of every member: A clear conscience, void of self-condemnation. If you so conduct yourselves throughout your career that in years to come, in the decline of life, you can look back and find no case wherein you can condemn yourselves for any failure in your duty, then will you appreciate the motto: "*Olim meminisse juvabit*," which doubtless expresses your present hope.

You now leave these halls of learning and for a time sever the friendships you have formed during the past four years. Friendships with your teachers which we trust may be strengthened by many years of intercourse to come, for we shall be glad at all times to hear from you all, of your prospects and successes in life, and be assured we shall at all times be ready to assist you by advice or otherwise. The friendly rivalry which has existed between you as fellow students will be continued in after life, and strive in these relations to be in charity with all men. If you differ in opinion with a professional brother, and become entangled in a dispute with him, be careful how you assert your own opinion, yield due deference to your opponents views, do not claim for yourself what you will not freely grant to him; but rather argue quietly the subject of disagreement, and be prepared to yield your own opinion if proved wrong as freely as you would demand his recognition of your view if his be proved erroneous, remembering always that absolute truth regardless of consequences is the object of our search.

Keep notes of cases occurring under your care ; they will be useful for reference, and will afford you material for future thought, and enable you to compare your own practice with that of others under similar circumstances ; be careful in noting the exact circumstances surrounding your case, often the most timid affords a clue to the explanation of some difficulty. Keep up your knowledge, what you have now learned will be only a basis to start upon ; you will find that what you now know in every branch of your studies will suffer loss by time and the multitudinous occupations of the practice of your profession ; it will therefore be necessary for you to read the current journals so as to keep posted with the latest views of others. This whole world is one of change, although in the cycles of years similar conditions may arise, although similar, they are never the same ; and as the diameter of a circle is a third and a fraction of the circumference, so you will find that the circle never comes back exactly to the same point, but that there is always a slight divergence.

I would press upon you the development of your chemical knowledge, and in doing so I may be thought egotistical ; but at the risk of such a charge I would still urge a devotion to that branch of your study, as I know of no branch which will give you more information or a more general opportunity of enlarging your minds. The laws of chemical union are definite under certain conditions, and it is the conditions under which chemical changes take place that require your special attention, and by close observation of the surrounding conditions you will eventually be led to a just diagnosis.

Devote a portion of your time to original research. The field of enquiry is ever expanding, and like the kaleidoscope, whose infinite changes are the result of a re-arrangement of a few particles, so we find in the world the mutation of elementary principles few in number as regards their surroundings, ever producing new developments, and as we recognize new departures from pre-conceived ideas, we gradually change our ideas to meet the requirements of the newly observed facts. The late experiments of Pasteur and the evidence he has

brought forward, show that the theories of physicians of fifty years ago were true; those physicians reasoning from analogy were correct, but they lacked the necessary experimental philosophy to prove their theories. We have vaccination as a preventive against small pox, who shall say how soon we may have a similar process as a preventive against other diseases, which a new condition of surroundings may make more common amongst us. I only indicate one line in which your original research may be continued, there are many others, from which each may select the one that best suits his taste.

And now having given you these few words of advice on behalf of your teachers, I bid you go forth on your business of life with its struggles and cares, and may the God of your fathers prosper you in all your undertakings.

ON THE TREATMENT OF PUERPERAL SEPTICÆMIA BY A NEW METHOD—INTRA-UTERINE SUPPOSITORIES OF IODOFORM.*

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[These Suppositories are made up with cocoa butter, holding finely powdered Iodoform together, in any strength required. They have been prepared for me by Mr. McGale, Druggist, St. Joseph Street, and Mr. John Lewis, of Victoria Square.]

The main object of this paper is to place before the profession a record of three cases of puerperal septicæmia, treated with iodoform, which have occurred to me in private practice within the last twelve months. I may say that I have been unable to find this plan of treatment previously recorded in the literature within my reach. The practice I advocate is the introduction within the uterus of suppositories, containing from ten to twenty grains of iodoform, night and morning, the idea being to replace the *frequent and often unsatisfactory intra-uterine injections of antiseptic fluids*. Iodoform as an antiseptic and cleanser of foul wounds on the surface of the body, has won for itself an

* Abstract of a paper read before the Medico-Chirurgical Society of Montreal.

honoured place in general surgery, and it occurred to me that it might also prove of value in lesions of the parturient tract. The site of the separated placenta has been compared to the stump of a limb after amputation. The lacerations of the cervix and following soft parts are but lacerated and contused wounds from a surgical point of view. And if iodoform has proved of signal value in these conditions in surgery, it is quite reasonable to suppose that it would also do so under similar circumstances in obstetrics. Feeling this view of reasoning to be logical, and that some good might come from it, I treated my cases in the following way:

Case I.—A. B., aged 23. Attended her 20th June, 1882. Fœtus dead some time and in an advanced state of decomposition. Amniotic fluid, dark and very offensive. In this case I washed out the uterus with a three per cent. solution of carbolic acid directly after delivery, and ordered nurse to use carbolized vaginal injections every two hours. All went well until June 23d (3d day), when patient had a severe chill. She became very restless towards evening. Temp. 104.5° F.; pulse, 130; flushed face. No pain complained of. Examination with Sims' Speculum showed passage quite clean, with very faintly offensive odour. By aid of forehead reflector I introduced a 15 grain suppository of iodoform, pushed to near the fundus with an ordinary stilette sponge tent introducer. Prescribed plenty of ice for her to suck.

June 24th, Morning.— Temp., 101° F.; pulse, 110. She had had a good night; no more chills. Washed out uterus with plain warm water, and introduced another suppository in the same way. At nine that evening temp. 102° F.; pulse, 115. Feels well; no chill. Introduced another suppository. Odor of Iodoform very strong, and powder covering thickly the external parts.

June 25th, Morning.—Temp., 99°F.; pulse, 86. Feels well; bowels acted freely during last night. Another suppository of 10 grains. *Evening.*—Temp., 100° F.; pulse, 100. Another suppository of 10 grains.

June 26th.—Convalescent.

Case II.—C. D., aged 30, fourth pregnancy. Attended Sept. 24th, 1882. Easy labor; all well.

Sept. 26th.—Found patient suffering intense perimetritic pain. Had had a severe chill some hours before. Temp., 103.5° F.; pulse, 126. Much excited; exclaiming she would surely die this time. Administered hypodermic of Battley, applied turpentine to hypogastrium, followed by linseed poultices. Washed out uterus with three per cent. sol. of carbolic acid as discharges were very offensive, and passed up 10 grain suppository of iodoform. *Evening.*—Much more quiet; temp., 104° F.; pulse, 130; passed up 10 grain suppository.

Sept. 27th, Morning.—Had a good night, no more pain. Temp., 100° F.; pulse, normal. Washed out uterus with plain warm water, and passed up suppository 10 grains. *Evening.*—Not so well; temp., 102° F.; pulse, 110; restless. Washed out uterus again with plain warm water, and passed up two 10 grain suppositories.

Sept. 28th, Morning.—Feels well; washed out uterus with warm water, and passed 15 grain suppository. External parts now thickly covered with Iodoform. *Evening.*—Temp., 101° F.; pulse, 100; 15 grain suppository.

Sept. 29th.—Same.

Sept. 30th.—Convalescent.

Case III.—E. F., aged 25. Third pregnancy. Attended her Dec. 13th 1882. Had given birth to twins at sixth month. Both fœtuses were quite fresh, and one was said to have moved at birth. Placenta was expelled and seemed entire. The condition of patient was peculiar. She seemed bordering on a state of delirium. Her skin was of a bright yellow color. Countenance had a wild expression. Temp., 105.6°; pulse, 160. Had had a series of recurrent chills ever since yesterday morning. She was at the moment suffering from an intense rigor. Examined uterus and found a piece of placenta, size of half an orange, firmly adherent to side of uterus near internal os. This I removed with curette and forceps; washed out uterus with three per cent. solution carbolic acid. Had no iodo-

form with me, and fearing the septic storm might prove too much for her, gave gr. xx quinine. She had been vomiting violently for the last eighteen hours, so that I do not think she retained much of the quinine. Had no peri-uterine pain whatever throughout.

Dec. 14th.—Much more quiet. Slept very little; temp., 103° F.; pulse still running high (140). Washed out uterus again with carbol sol.; discharge very offensive; introduced two 10 grain suppositories of iodoform. *No more quinine* nor medicine of any kind. *Evening.*—Temp., 100° F.; pulse, 120. No tenderness whatever over uterus, even on forced pressure. No more vomiting.

Dec. 15th.—Fair condition. Temp., 100° F.; pulse, 112. Bowels very loose during night. Skin and conjunctivæ still very yellow; some tympanites. Washed out uterus with plain warm water; introduced one 15 grain suppository. *Evening.*—Not so well; temp., 102° F.; pulse, 120; *no more suppositories at hand.* Washed out uterus with acid carbol sol.

Dec. 16th.—Very bad night. Diarrhœa again set in, also vomiting. Temp., 103.5° F.; discharge fœtid; pulse 124. washed out uterus with plain water, and passed up two 10 grain suppositories of iodoform. *Evening.*—Feels better. Did not wash out uterus, but introduced one 10 grain suppository; parts now covered with iodoform powder. Temp., 102° F.; pulse, 110.

Dec. 17th.—Temp., 100° F.; pulse, 110. No more chills nor vomiting; bowels quiet. From this date until the 21st she remained about the same, and had received one 10 grain suppository night and morning.

Dec. 22nd.—Quite convalescent.

Remarks.—A peculiar feature in the above cases consists in the fact that each of these occurred within a few days of three months of each other; and that although I had attended other patients but a few hours after each case, I did not convey the disease. This we must accept as strong evidence in favor of the good to be obtained by thorough disinfection before examining each new case of parturition.

In the first case it is evident the immediate cause was auto-infection. In the second case I found the nurse had been using an imperfect syringe (no valves), and instead of carbolized water she had been throwing a stream of air loaded with bacteria from a badly ventilated room against the lacerated internal parts. This no doubt was the cause of the trouble.

In the third case the patient had been suffering from septic infection eighteen hours prior to my attendance. At a previous confinement the perineum, sphincter ani and septum were lacerated. The uterus was in the second stage of prolapse, thus exposing the os constantly to the external air, a condition favorable to the entrance of germs. Under such circumstances it can be easily understood that when partial separation of the placenta took place, and blood became effused into and around the seat of lesion, it was an easy matter for germs to find in this blood a suitable soil for their destructive work. Here we have a case of undoubted severity. All the symptoms at the outset of the disease indicating rapid and extensive absorption of virus, notwithstanding which, the marked influence of iodoform in arresting further absorption was most evident. The single dose of quinine the patient had taken on the first evening would have lost its influence at the expiration of twenty-four hours; and the washings, chiefly with plain water, were repeated only at intervals of twelve hours apart; and the only occasion upon which the iodoform was omitted, was followed by symptoms of severe sepsis.

Iodoform as a parasiticide is well known to be one of low power. This I have proved by direct experiment with animal matter outside of the body; but as an antiseptic in such cases as I have recorded, its chief virtue rests in the slow and continuous giving-off of its vapor, so that once the endometrium becomes thoroughly coated over with the powder, and there are occasional simple washings practiced, say night and morning, the uterus becomes an aseptic chamber.

Bacteria are of themselves, we know, harmless in the blood and tissues, probably on account of a catalytic action of the latter. But when they are provided with fluids in or out of the body

which have lost their catalytic action, they, as the yeast plant in the presence of grape sugar, set up fermentation, the result of which is a *virus*, which, when it finds its way into the blood, gives rise to septicæmia. Now we know that iodoform, quinine, and other agents (Bintz) have the power of paralyzing and preventing the migration of leucocytes; and these agents may also have the power of paralyzing germs, and arresting the process of animal fermentation—so to speak—and thus prevent or modify the production of infective virus within the cavity of an organ like the uterus. It is not often material for experience in this terrible disease presents itself to us, nor are we anxious to seek it; but in the limited experience I have had with the above cases, I am convinced of the *unequalled* value of iodoform. And I most conscientiously say that in future I shall not feel that very unpleasant anxiety, so difficult to put aside from us in treating these cases, as I have felt in the past.

In conclusion I may say that in carrying out this treatment by suppositories of iodoform, I place the patient on her left side, retract the perineum with Sims' speculum, and when the os and cervix have come well into sight, I irrigate the uterus for a few minutes with a No. 3 Goodyear rubber fountain syringe; any fluid according to choice can be used. Then I pass a suppository of iodoform on an ordinary stilette sponge tent introducer, to the center of cavity of uterus and withdraw the instrument. At most it is only necessary to repeat the operation night and morning, and the irrigation only for the first two or three days, to thoroughly cleanse the uterine cavity, after which the iodoform will keep it sweet.

CASE I.—A. B.—(Treated by Iodoform Suppositories and *no* Quinine.)

23rd June—Temperature		M., ———	E., 104°F.
24th	"	"	M., 101°F.	E., 102.2°F.
25th	"	"	M., 99°F.	E., 100°F.
26th	"	"	M., 98.4°F.	E., 98.4°F.

CASE II.—C. D.—(Treated by Iodoform, *no* Quinine.)

26th Sept.—Temperature		M., 103.4°F.	E., 104°F.
27th	"	"	M., 99.8°F.	E., 102°F.
28th	"	"	M., 98.4°F.	E., 100.8°F.
29th	"	"	M., 98.4°F.	E., 98.4°F.
30th	"	"	Normal.	

CASE III.—E. F.—(Treated by Iodoform and one dose, gr. xx, of Quinine.)

13th	Dec'r—Temperature.....	M., 105.8°F.	E., ———
14th	"	"	M., 103.6°F.	E., 101°F.
15th	"	"	M., 100°F.	E., 101.8°F.
16th	"	"	M., 103.4°F.	E., 101.4°F.
17th	"	"	M., 100.8°F.	E., 101.4°F.
18th	"	"	M., 100°F.	E., 102°F.
19th	"	"	M., 99°F.	E., 100.4°F.
20th	"	"	M., 99.2°F.	E., 100°F.
21st	"	"	M., 98.4°F.	E., 99.8°F.
22nd	"	"	Normal.	

ON A CASE OF LEUCOCYTHÆMIA.

BY G. TILLERIE ROSS, M.D., MONTREAL.

[*Read before the Medico-Chirurgical Society of Montreal.*]

J. S., aged 24, married, a native of Quebec, was, in January, 1882, suffering from an attack of jaundice, for which I was called to attend.

Previous history.—When seven years of age he removed from Quebec to Altona, near Hamburg, North Germany, where he resided 14 years. This district is said not to be malarial. Returning to Quebec, he remained there 1½ years, since when he has continued to reside in Montreal. While in Germany he had both scarlatina and pertussis. Shortly after recovering from these diseases, he received an accident which injured his bladder and necessitated his confinement to bed during some four months. Till that time, with exception of the diseases referred to, his health was claimed to have been vigorous, but subsequently he never regained the same robust health. Some two years ago he noticed a swollen gland in left inguinal region, which was said to have appeared after a great strain in lifting a stove. This was lanced, but it is said that only blood issued from it. Four months thereafter he was married, and neither the wife, nor the child subsequently born to them, have, up to the present time, given any evidence of specific disease. The patient now began for the first time to notice himself subject to attacks of epistaxis, occurring once or twice a week, sometimes varying to the same number per month. In January, 1881, severe headaches would trouble him frequently, with loss of appetite and strength. About

June, '81, he noticed his abdomen becoming larger. No history of ague. Habits were always temperate.

Family history.—Both parents said to have had good health. His mother still lives; father died at 49 years. Has one brother, whose health is good. No history of any tendency to epistaxis in the family, malaria, or syphilis.

Present condition.—A man of ordinary height and of spare build; chest concave under clavicles and walls so thin that heart's pulsations are distinctly seen. Cardiac impulse increased, and apex beat nearly in line with left nipple. From 3rd costal cartilage to 5th interspace the pulsations are distinct. Second sound has increased intensity over pulmonary cartilage. No murmur present. Abdomen greatly enlarged, being in marked contrast to the sunken, shallow chest. Distension of abdomen uniform, and walls tense. A solid mass is felt on left side, giving a sense of resistance on palpation; it is firm, hard, and reaches below level of crest of ilium, extending beyond median line. At a point two inches below zyphoid cartilage the abdomen measures 32½ inches. A distinct notch can be felt in the well-defined edge of tumor. No evidence of fluid to be made out. Hepatic dullness does not extend below margin of ribs. Glands of axillary, inguinal and cervical regions sensibly enlarged. No dropsy of feet or limbs. Cutaneous circulation very prominent. The skin and conjunctivæ are deeply tinged with bile. Has been jaundiced for some days past. No appetite. Temperature normal. Urine dark; no albumen. Under treatment the jaundice disappeared in some eight days, and being of economical disposition, the patient did not desire further attention, as he felt well enough again to resume his business. To take Ol. Morrhuæ and an iron tonic mixture.

July 20th, '82.—Called to see patient, who complained of great pain across abdomen; said it was persistent and unbearable. Breathing hurried. Temperature, 102; pulse, 118; respirations, 32. Abdomen measures 33 inches at same level as previous measurement, showing increased circumference of half an inch since January last. Marked tenderness on pressure over sternum, extending from 3rd costal articulation two inches down-

wards. Great weakness complained of. Cervical, axillary and inguinal glands can be felt, but not conspicuously enlarged. Since his recovery from jaundice six months ago, patient says his health has been pretty good, not interfering with his business, although never free from a sense of weakness, with occasional severe headaches and recurring epistaxis. He is not markedly anæmic ; lips and mucous membranes have good color. Expression is listless and apathetic. No dropsy present. Ordered hot linseed poultice to abdomen, sprinkled with laudanum, and to have quinine and iron internally. The following day he was relieved of pain, with temperature 99°F., pulse 85, and respirations 25. A day or two afterwards, Dr. R. P. Howard saw the case in consultation. He gave an unfavorable prognosis, advising that iron and arsenic should be administered. Blood examined under microscope showed a great increase of white corpuscles, but the proportion to red was not ascertained till later.

Aug. 26th.—Increased hepatic dullness was evident, but no return of jaundice, nor any tenderness over liver ; no marked change in patient's condition. Weakness chiefly complained of, and shortness of breath on exertion. Appetite good ; temperature, 99°F. Attends his shop pretty regularly, although the headaches persist as before, and sometimes their severity compels him to remain in bed. Tenderness over sternum reaches from 2nd costo-sternal articulation to zyphoid cartilage.

Aug. 29th.—Complains of pain at a point one inch below sternum, in median line, which is aggravated on his changing his position. Examination of blood showed red corpuscles in cubic millimetre =3.450,000 ; per hæmic unit, 69 ; ratio white to red, 1 to 6½. The microscopic character of red corpuscles showed uniformity, and lacked the microcytes common to pernicious anæmia. Other examinations of blood were made, but the variations from above result were not striking, the last being made about the 7th January. Unfortunately, the memo of exact figures was mislaid. The measurement of abdomen gives no increase or diminution from last.

Dec. 20th.—During the past few months the patient was not under observation, having been out of the city. The nose-bleed-

ing and headaches have continued at intervals, but otherwise he has been sufficiently well to give partial attention to business. Abdominal measurement has increased ¼ to ⅜ of an inch; liver dullness also increased. Had another attack of jaundice since I saw him. No dropsy or decided anæmia. Chest and limbs assuming emaciated appearance. Cutaneous veins of chest and abdomen very prominent. Says that now he is too weak, and must give up business. Appetite fairly good and bowels regular. Dyspnœa on exertion is more distressing than before. Temperature and pulse normal. Urine pale straw-color, contains urates, no albumen. Ordered port-wine to be taken with meals, and to have Fer. and Phos. pills.

Jan. 7th, '83.—Attacked with bleeding from one of lower incisor teeth, which was arrested after considerable difficulty. Recently his appetite has been unusually good, and his wife says he indulged it freely. Is too weak to walk about, and leaves bed only to lie upon the sofa. Abdominal distension is such that it is a burden for him to stand upright. Sleeps a great deal and desires to be free from disturbance of any kind. Complains of constant dizziness. When changing his position, increased vertigo ensues. Arsenic and iron continued.

Jan. 10th.—Another attack of bleeding from gums. Patient continues now in bed owing to his weakness. Appetite good; takes large meals; digestion good; temperature normal.

Jan. 15th.—Diarrhœa set in last night, and great weakness now complained of. Temperature, 99°F.; pulse, 85; respirations, 30. To-day he finds continuous noises and buzzing in his ears, so much so as to materially lessen his hearing. All medicine stopped, except diarrhœa astringent powders.

Jan. 18th.—Noises in ears have continued up to the present, and to-day are greatly aggravated, hearing being now impossible. Questions require to be written, and these are read with difficulty. Eyes were not examined, as patient objects to being disturbed. Diarrhœa is less frequent, but not entirely arrested.

Jan. 22nd.—Very severe headache; marked intolerance of light; same return of nose-bleeding. Diarrhœa persists; lies apathetic and drowsy; questions written and held before him

are disregarded. He places hand over hypogastric region and says it is painful ; find tenderness on pressure here. Urine now passed in bed prevents its being tested. An attempt to pass catheter caused intense pain. Hot fomentations, demulcent drinks, and opiates ordered. Temperature, 101°F. ; pulse, 120 ; respirations, 30.

Jan. 23*rd.*—Lies almost comatose ; can be roused, but quite deaf ; labored and distressed breathing ; strength quickly failing. To-day there is decided divergent strabismus of left eye, the pupil of which is dilated. Complains of pain over both eyes. No urine obtainable, excepting by catheter, which brought away a small quantity of ammoniacal urine. Great tenderness on pressure continues over bladder and abdomen generally. Some diarrhœa still ; temperature, 99°F. ; pulse 76, and weak ; respirations, 34. To have stimulants every hour, with opiates. 10 *p.m.*—Gives evidence of suffering, but is insensible to surroundings ; weakness of pulse more marked ; no nourishment taken to-day ; no increase of temperature ; respirations, 35.

Jan. 24*th*, *a.m.*—Continues comatose ; abdominal tenderness great ; passes urine and fæces involuntarily. Some bleeding from nose last night ; pulse very feeble. Died at 5 p.m., after what the friends present described as a hard struggle, gasping for breath.

Autopsy 30 *hours after death.*—Body emaciated, skin livid, abdomen distended, no dropsy. In abdomen, omental veins much distended ; in peritoneum, uniformly injected. Spleen greatly enlarged, reaching below anterior superior spine of ilium. *Thorax*—A few adhesions, but no fluid in pleuræ. Pericardium distended by an enormous heart ; contains a couple of ounces of clear serum. Heart very large ; all chambers greatly distended, with tolerably firm chocolate-colored coagula ; weight of clots in chambers alone, not including veins, is 620 grms. ; valves normal, substance pale ; arteries and veins leading from the heart distended with brownish clots. Lungs crepitant, a little congested at bases ; vessels very full. Mediastinal lymph glands enlarged. *Spleen*—No adhesions whatever ; before excising, the portal system was carefully dissected out ; vessels all enor-

mously distended with clot; circumference of portal vein, just above junction of the branches, is 11 centimetres. Splenic vein very large, joined by four or five large branches leaving the spleen, and joined by other greatly distended veins from the stomach. Spleen weighed 7½ lbs., and measured 13 by 8½ inches. Shape is preserved. No special thickening of capsule. Fibrous stroma not specially evident. Malpighian bodies not enlarged; no localized lymphoid growths; under microscope, shows simple hyperplasia of normal spleen elements, cells of the pulp and red blood corpuscles form chief elements of structure. In bits examined, only one or two nucleated red blood-corpuscles are seen. *Liver* fully twice normal size, smooth, somewhat soft, veins distended. The microscope shows an increase of colorless blood corpuscles mingled with liver cells. *Stomach* shows no special change. *Small intestines*—Veins distended; no enlargement of Peyer's patches; solitary follicles are uniformly enlarged. Blood altered in upper part of intestine, and general catarrhal state of both small and large bowel. *Kidneys* enlarged, dark color; veins deeply congested; cortex swollen. *Bladder* contains dark, ammoniacal urine; mucous membrane intensely inflamed and covered with a small amount of exudation. Mesenteric and retroperitoneal lymph glands enlarged, soft and red in color. *Marrow of sternum* and of ribs looks like thick greyish, bloody pus; under the microscope, shows numerous marrow cells, very few myeloplaques and nucleated red blood-corpuscles; the latter less than in many specimens of normal red marrow. Small lymphoid elements not specially numerous. *Brain*—Extreme degree of engorgement; arteries at base full of clots. Veins greatly distended, and, on section, puncta vasculosa are unusually numerous. Choroid plexus and velum are engorged. Substance of brain is somewhat soft, but presents no special morbid change. *Eyes*—Both retinæ presented extensive leukæmic changes in the form of opaque white spots, surrounded by congested and hemorrhagic areas. The discs were not swollen.

REMARKS.

Up to the present time, it is a disputed question as to who was the discoverer of this uncommon disease, for Hughes Bennett

lays claim to that honor, having described a case in March, 1845, saying that the blood contained "globules of purulent matter and lymph," where there was an entire absence of phlebitis, abscess, or purulent collection to which the state of the blood might be attributable. Then six weeks afterwards, Prof. Virchow published the history of another case, and called it *Leukæmia*. This author, in later observations, separated two forms of leukæmia, viz., *splenic* and *lymphatic;* but the most frequent cases coming under observation are the mixed variety, where both spleen and lymphatics are affected, and to the latter the present case belongs. While this authority asserts that leukæmia first begins by the hyperplasia of a lymphatic organ, Kattman and others say that primarily an increase of the blood-cells takes place, occurring in the blood itself, and that what are called the blood-forming organs subsequently become hyperplastic. To-day the former view appears to be generally accepted. Cases are recorded where all the phenomena of leukæmia were present, excepting the important one of increase in white corpuscles, these cases being termed *Pseudo-Leukæmia*, *Lymphadenoma*, or *Hodgkins' disease*, making it appear likely, in the opinion of some authors, that the increase of these bodies was more incidental to the disease than that it constituted the disease itself. According to Huss, there must be an increase of white corpuscles in proportion of 1–20 red in order to pronounce the disease leukæmia.

Wherever lymphatic glands are the seat of irritation, an increase in white corpuscles occurs, as in typhoid, cancer, and malignant erysipelas, but the proportion is never so great as in the disease under consideration. In this case no notable augmentation was observed of the small lymphoid elements, such as are said to specially characterize the so-called lymphatic variety, although the autopsy showed considerable enlargement of the lymphatic glands. No definite origin for the disease can be traced in the facts before us. This coincides with most of the cases observed, for there is acknowledged obscurity regarding the causes of this disorder. Special enquiries regarding malaria were carefully instituted, with no satisfactory result. On asking

the patient when his attention was first directed to the growth in abdomen, he replied that as long as he could remember it was always hard. His wife's evidence is more reliable here, for she remarked the peculiarity from the date of their marriage, over two years ago, so that during this time at least the growth existed in sufficient proportions to cause attention to its more evident result, viz., tenseness of the abdominal walls. What little evidence we have here does not differ from the general rule in leukæmia—that its course is an insidious one. The course was lingering and continuous; complaints were frequent of dullness and headache, dyspnœa, pressure and fullness of abdomen. Neither age, sex, nor social position is free from liability to leukæmia. The greater number of cases recorded have been in the male sex. Amongst its causes are given excessive mental or bodily exertion and continued excitement, chronic intestinal catarrh, leading to hyperplasia of the solitary glands and Peyer's patches, syphilis, long-continued and obstinate intermittent fever, and the influence of the nervous system in depressed states of the mind, are all known to have given rise to the malady. Yet, notwithstanding the most careful inquiry, no direct cause can in some cases be found for this mysterious disease. Another cause, which, however, is regarded as problematical by some, is that of traumatism; a few cases are mentioned by Velpeau and Wallace, where a blow in the splenic region was the direct antecedent. In our present case, we know only of severe injury being sustained by the bladder many years ago, after which, however, the patient averred his standard of health was unquestionably lowered.

According to Hughes-Bennett, the complications of epistaxis and diarrhœa are the most common, the former of which stands out as a prominent symptom in the present instance. Here no hereditary tendency to bleeding existed, yet hemorrhage recurred with persistence throughout the course of the affection. Although this exhausting condition recurred from time to time, it was not until within a couple of months from his death that he was obliged to refrain from physical exertion; but this may be accounted for by the fact that the end was hastened through the onset of a

new complication, viz., acute cystitis, and the aggravation of existing ones. There was never profound anæmia present. This case would not support the theory, therefore, that leukæmia was developed from pre-existing anæmia. It is well-known, however, that the hemorrhagic diathesis has frequently preceded enlargement of the spleen and subsequent leucocythæmia. The red corpuscular richness did not vary much, it having been, at first count, 69 per hæmic unit. This would explain the lack of anæmic appearance in the patient, for anæmia does not so much depend upon the increased quantity of white corpuscles as upon the decreased quantity of red. Would improvement in the condition of the blood, when under treatment, indicate improvement or arrest of the disease? Clinical experience shows that it would not, and it is established that improvement in the blood of splenic leukæmia is no evidence that the constitutional symptoms shall cease, or that the patient will recover. While the red corpuscles are diminished, the water and fibrin are increased. This condition was evidenced at the autopsy. The chocolate-colored blood of leukæmia was presented, but different from what is usual, since all the chambers of the heart were greatly engorged, as if the action of the organ had been suddenly arrested. Perhaps this was the most remarkable feature noticed in this uncommon case, for the condition of the circulation greatly resembled the state found in death by apnœa, with the exception, that instead of the left chambers of the heart being empty, all the chambers were engorged with enormous clots, the weight of which has been stated. The brain, heart, lungs, portal system, kidneys, omentum—in fact, all the viscera—were engorged to a remarkable degree. Sir Joseph Fayrer, in the last January *Lancet*, called attention to the fibrinous condition of blood in diseases of the spleen, and alluded to the liability of thrombus forming in the vessels. He also spoke of the tendency of the fibrin to precipitate and form ante-mortem coagula, particularly in splenic disease resulting from malarial poisoning, by this means frequently causing sudden death through obstruction in the pulmonary vessels leading to the lungs. In the case before us, there was neither sudden death nor deposit of fibrin,

yet would this be sufficient to exclude the condition of hyperinosis described by the authority named, when every other evidence of well-developed leukæmia was present?

Under the symptom of hemorrhage, I will refer to a very uncommon lesion which complicated this case, viz., *Retinitis*. The indications of eye trouble did not present themselves until a very late stage in the course of the disease, at a time, indeed, when examination was not feasible; but the autopsy revealed inflammation of the retinæ of both eyes through hemorrhage into their substance, and the exudation of white cells. The acute disorders which supervened, viz., diarrhœa and cystitis, undoubtedly hastened death. The former was persistent, and only yielded temporarily to remedies. It consisted of an intestinal catarrh, for what passed the bowels was chiefly mucus. I could not discover the origin of the cystitis, for there was no mechanical irritation to occasion it, nor inflammation in the bowel or any adjacent organ which might extend and give rise to it. The only conclusion was that through some unwise exposure of the body a chill had set up the complication. The congested condition of the venous circulation may, perhaps, be sufficient to explain the constant headaches from which the patient suffered. Jaccoud, in his "Pathologie Interne," says that persons who succumb to leucocythæmia not infrequently have several hemorrhages. These, he states, occur oftenest in the brain, caused by an accumulation of leucocytes blocking up some small vessel, which, acted upon by the blood-pressure, tends to rupture.

In the transactions of the London pathological Society, the condition of the vessels is referred to in connection with cases of lymphadenoma. It was very conspicuous in many sections of affected organs, numbers of the vessels being seen mapped out and tightly packed with masses of colorless corpuscles. In a few cases only of this last-named disease was the condition absent. In some cases the degree of leucocytosis deserved the name of leucocythæmia, the proportion of white cells to colored being greater than 1–20. Where these conditions so closely approximate each other, what is there to constitute absolute proof that the invasion of adenoid growth in any gland may not

go on to the disease we are considering. The gradual development of leukæmia which has been noticed in certain cases of splenic enlargement in children surely indicates that it is a disease secondary in some cases, and the fact that leucocytosis is found under different conditions points to the possibility that the rarer appearance of leukæmia may be merely the result of certain states which tend to produce an increase in the white elements. Leukæmia is not the rule in lymphadenoma, and even in its extreme forms, with the spleen affected, leukæmia may be absent A patient has been known to die rapidly of apparently malignant disease, when the only lesion post-mortem was found to be slight enlargement of a few glands and a leukæmic condition of the blood. This is what is termed Virchow's lymphatic variety, but the cases are extremely rare, and the cause of death would be difficult to explain, were it not for the evidence given by the blood, because growths of the same nature occur in lymphadenoma, affecting not only the lymphatics, but invading important organs, and still the patient survives for many years. In these cases, during the active growth of the glands, the most marked symptoms are high temperature and diarrhœa. In cases where the glandular growths were limited, and leukæmia present, it would support the view that leukæmia was not so much due to these growths as to want of power in lymph and white corpuscles to form red ones, or, as referred to before, from some disease of the blood the white corpuscles acquire a definite power to magnify and increase themselves.

In reference to the bone marrow, it was shown by Neumann that the pathological changes favor the theory of importation of lymph corpuscles into the blood from the marrow. Their passage he explains by the morbid changes in the marrow, where the blood corpuscles, before reaching maturity and full development in the bones, pass into the circulation. He places this change in the marrow of leukæmia as the only one of constant appearance, and that the affection of the spleen and glands are only incidental thereto. This is known as the myelogenous form of leukæmia, and Jaccoud says it should to day be placed side by side with those forms better known and recognized. On the other

hand, Waldeyer relates a case of leukæmia where the change in the marrow was not so marked in comparison to the size of the spleen and glands as to warrant the belief that the marrow hyperplasia could be called the primary affection. In his cases illustrating diseases of the lymphatic system, Dr. Goodhart says: "In regard to medullary leukæmia, I can readily conceive that "the disease might as well start at times from the bones or from "other lymphatic organs as from the spleen or glands, but the "proof must come, not from the mixed cases such as those pub- "lished by Neumann, Mosler and others, but from the side of "diffused cancers, or soft lymphomas of bone, spreading through- "out the whole osseous system. That all cases of chronic en- "largements, from whatever source, may become, though not "necessarily, leucocythemic," and he also thinks "that some "of the chronic splenic enlargements of childhood may even- "tuate, in adult life, in leukæmia."

The liver is often diseased in leukæmia, generally from hyperplastic increase of the cells and colorless corpuscles, which was found in this case. Mosler observed a case occurring with jaundice where cirrhosis was found, and inferred that the change took place by a proliferation beginning in the connective tissue.

The kidneys are usually normal, but here they were swollen, enlarged, and congested.

The treatment I have not given in detail, but may state generally it was palliative and symptomatic, as the indications arose, combining tonics, nutrients and stimulants to support the vital powers. The question arises in cases of lymphadenoma, if they are infective and local at the outset, as it is asserted they are by competent authorities, why not remove the cause rather than permit them to remain infecting the system and generating leukæmia eventually. Previous failures in this direction have been most discouraging, one successful case only being known; but it should not prevent the repetition of attempts in suitable cases, for though a symptom has been removed, the cause itself has not been discovered, and therefore has not been eradicated. In the meantime, while searching for the cause, we must treat the symptoms.

CASES OF CEREBRO-SPINAL MENINGITIS.

By G. A. ARMSTRONG, M.D.,
Professor of Anatomy, University of Bishop's College.

The report of the two following cases of cerebro-spinal meningitis may prove of interest from the rarity of its occurrence in Montreal and the severity of the symptoms :—

Case I.—A little girl, aged 6 years ; seen January 9th, '83. Was told that she had been a little feverish for two or three days, but complained only of headache. She lay in her mother's arms in a semi-unconscious state ; eyes open, pupils dilated, breathing rapid, no cough, and vomiting occasionally. Any attempt to examine her, even to count her pulse, provoked a tonic contraction of the muscles of the back and neck. Her pulse could not be counted with any certainty on account of the contraction of the tendons of the wrist. Her temperature was 104°F. ; respiration normal over both lungs, with the exception of a few large bronchial râles. There were no petechiæ or herpes. The hyperæsthesia was very great. The next day, the condition of opisthotonos was marked and persistent ; the child was comatose. Died the following morning. Duration of illness, about 72 hours. The treatment consisted in the free administration of potass. iod. and counter irritation to nape of neck and spine, followed by ice.

Case II.—A little boy, aged 4 years, strong, fat and active. When a year old, had measles, following in a few weeks by whooping cough. At three years of age, had a convulsion, supposed to be due to a worm which was passed at that time after the administration of worm lozenges. On Saturday, 31st March, the boy was quite well and playing out of doors all day. Got his feet damp. In the morning he ran out for half an hour bare-headed. The next morning, April 1st, he got up as usual, but took no breakfast. At 2 p.m. I found him in a semi-unconscious state ; would pay no attention to any one ; would not answer when spoken to. He seemed agitated, his arms always moving ; extremities cold ; eyes open, balls turned up ; pupils nearly normal ; right eye turned inwards and upwards ; breathing very

rapid. Mucous and submucous râles heard over back and front of chest. No dullness on percussion; no blowing breathing. Pulse, 120; temperature, 103°F. Ordered mustard to nape of neck, calves of legs and soles of feet, and a mixture containing potass. bromid. 9 *p.m.*—Pulse 160; temperature 106.5°F. Is generally in the same condition as at 2 p.m, with rapid and continuous convulsive twitchings of hands and arms. Ordered a strip of mustard an inch wide to be placed along each side of the middle of the back, an inch from the spines of the vertebræ, and to extend from neck to lumbar region, to be followed by ice to head and along the back, over the spine.

April 2nd.—Pulse, 176; temperature, 101.6°F. Hyperæsthesia very great. Is vomiting a black fluid, streaked with blood. Small petechial spots, about twenty in number, seen over chest and side of face. No herpes. Large purple discolorations over the thighs. Ordered Pot. Iod. grs. v; Pot. Brom. grs. v; Liq. Ergot, ♏ v; every two hours. 4.30 *p.m.*—Conjunctivæ congested; right pupil a little larger than left. No reaction of either pupil to light. Is completely comatose. Dr. Reddy saw him in consultation, and confirmed my diagnosis. He advised a hypodermic injection of morphia and atropia, which was given, and seemed to allay the spasmodic contractions of arms. Dr. Reddy thought the cold applications to spine might be changed for warm ones, which was done. No apparent benefit followed. Vomiting continues.

April 3rd.—Died at 1.45 a.m Duration of illness, 42 hours.

The rapidly fatal course of these two cases, the severity of the symptoms, and the very high temperature of the second case (106.5°F.), are points of interest occurring in sporadic cases.

Hospital Reports.

MEDICAL AND SURGICAL CASES OCCURRING IN THE PRACTICE OF THE MONTREAL GENERAL HOSPITAL.

UNDER THE CARE OF DR. MOLSON.

CASE I.—*Extensive Warty Endocarditis in a case of Phthisis.*

M. R., aged 28, admitted to Hospital January 8th, 1883. Patient was sent to hospital on account of cough, but during the

night it was found she was quite maniacal. Previous history, so far as could be made out, was : Had been married 11 years ; had three children ; last confinement about middle of October, and made a good recovery. Was said to have been a healthy woman, but with occasional cough since marriage. For the last six weeks cough has been much worse, and has been losing flesh rapidly. First attack of mania about one month after confinement, and has been more or less out of her mind ever since.

On examination, consolidation of upper two-thirds of right lung found. Patient remained in hospital; was maniacal for about four weeks, after which she appeared quite sensible. Had the usual signs and symptoms of a rapid phthisis—irregular fever, quick pulse, profuse night sweats, diarrhœa, and severe cough. Died March 27th. Before death, signs of extensive disease in both lungs and pleurisy of right side. Heart was examined on admission, but never after, as no suspicion was entertained of any acute trouble there.

Autopsy.—Liver pushed down. In right pleura, extensive adhesions above ; pyo-pneumothorax on diaphragmatic surface. Large communicating cavities at apex of right lung ; extensive tuberculous consolidation, with softening areas in middle lobe and upper part of lower. Recent inflammation in lower zone of pleura ; exudation purulent. On under surface of lower lobe, about $1\frac{1}{2}$ inches from anterior margin, there was a large circular perforation leading into a cavity the size of a walnut. In the left lung, numerous cavities at apex and in upper part of lower lobe. The heart was of average size ; right chamber full of clots. In left ventricle, auricular surface of mitral segments presented six or eight recent vegetations, ranging in size from a pin's head to a pea. Near the posterior papillary muscle a large, soft endocardial outgrowth was attached to the wall, and grew round and enclosed two of the chordæ tendineæ.

Case II.—*Cerebro-Spinal Meningitis—Recovery.*

L. C., aged $2\frac{1}{2}$ years, admitted to Hospital Feb. 7th, 1883, in the following condition :—Child lies on either side, with head rigidly drawn back. No rigidity or paralysis of extremities.

Face dull and heavy ; eyes watery ; conjunctivæ injected ; teeth covered with sordes. Abdomen about natural fullness. Marked "tache cerebrale." Temperature, 98°F. ; pulse, 108, intermittent ; respirations, 30, with occasional sighing. Child is restless, moans continuously, but appears quite conscious. If moved about, or extremities handled, she cries out as if in pain. The mother states that on the morning of the 5th, two days before admission, the child was in her usual health. During the day, had a severe shivering fit, and soon became dull and heavy, complaining of great pain in back of neck and general soreness ; had frequent vomiting of a greenish fluid, and would cry out if moved. No headache. Child passed a restless night, moaning all the time ; frequent vomiting. The day before admission, retraction of head commenced ; great pain in back of neck ; general soreness, aggravated by movement ; frequent vomiting. Child quite rational. To have Pot. Iod., gr. iii, 3 q.h.

Feb. 8th.—Child heavy and apathetic if left quiet. Appears rational, though some delirium during the night. Marked hyperæsthesia ; retraction of head extreme ; pupils normal ; bowels moved naturally ; passes urine in bed ; temperature, 99°F. ; pulse, 138 ; respirations, 38.

Feb. 9th.—Child appears much worse. Pulse over 160 ; temperature, 104°F. ; respirations irregular and sighing. Retraction of head the same. No vomiting ; bowels moved naturally. Child is very apathetic to-day, but answers rationally. No complaint of pain.

Feb. 10th.—Not much change since yesterday, except child is weaker. Tongue getting dry and brown. Bowels move every day ; urine passed in bed. Pupils dilated. Some purulent secretions about eyes. Child lies on one side, with head rigidly drawn back. Temperature last night and this morning, 100.5°F. Pulse cannot be counted.

Feb. 11th.—General condition no worse. No vomiting ; some diarrhœa. Body and extremities covered with rose-color spots, quite distinct from each other ; a few small petechial spots.

Feb. 12th.—Patient much better ; pulse stronger ; temperature, 100°F. ; hyperæsthesia diminishing ; rash fading rapidly ; retraction the same.

Feb. 17*th.*—Eruption almost gone; retraction of head unchanged. Passes urine and fæces in bed, but child is much brighter. Pulse improving, and down to 130; respirations, 30. Takes nourishment well, sleeps well at night, and has now no increased sensibility of skin.

Feb. 21*st.*—Child getting stronger. Temperature goes up as high as 101°F. occasionally. Some retraction of head; occasional vomiting. 28*th.*—Retraction of head almost gone; no vomiting; temperature normal; appears somewhat dull yet.

March 15*th.*—Child quite better; is now bright and intelligent; a little weak, but gaining flesh, and taking nourishment well.

UNDER THE CARE OF DR. GEORGE ROSS.

CASE III.—*Cerebral Hæmorrhage—Sub-conjunctival Ecchymosis—Autopsy—Small Aneurism at base.*

F. E., aged 17, shoemaker, well-built, admitted to Hospital insensible on the evening of Dec. 18th. Patient lies in bed, eyes closed, pupils contracted, muscles of arms and forearms rigid and flexed, legs slightly rigid, but straight; respirations stertorous, 18 a minute; pulse small, 100; temperature normal. Said to have been healthy till one year ago. During past twelve months has had several very severe attacks of nose-bleeding; several times bled till faint. Three months ago is said to have had an epileptic fit, from which he recovered in ten minutes. For the past eight days has had severe headache; very bad for the last 48 hours. Two hours before admission, went out into the yard, where he was found insensible half an hour after. No suspicion of foul play.

Dec. 19*th.*—Still unconscious; general condition the same. Pupils normal and respond to light. Passes urine in bed; small quantity obtained with catheter, no albumen. 8 *p.m.*—During the day muscles not so rigid. Very few spasms now. Both eye-balls very prominent. Slight ecchymosis in right upper lid and under ocular conjunctivæ. Left pupil dilated; right about normal. Leeches applied behind ears, ice to head, and a purgative.

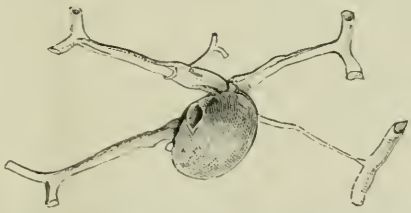
20*th*.—Unconscious; arms rigid; legs relaxed. Several attacks of clonic spasm in arms and down back. Cheyne-Stokes respiration. Ecchymosis deepening around right eye; beginning around left. Left pupil still larger than right. Temperature going up; skin warm and perspiring.

21*st*.—To-day limbs are quite relaxed; opens eyes from time to time, but does not appear conscious. Examination shows optic disc engorged and veins full. Ecchymosis not increased. Temperature going up; pulse 125, and very feeble and dicrotic.

22*nd*.—Profoundly unconscious; limbs and sphincters relaxed; pulse and temperature going up; skin hot and perspiring freely.

23*rd*.—Pulse continued to increase in frequency; temperature going up; perspiring freely. Died this afternoon.

Autopsy.—Extensive hemorrhage at the base of the brain, involving the meninges, anterior to the optic chiasm, and extending into the longitudinal fissure, and over the anterior part of the corpus callosum. On separating the orbital surfaces of the frontal lobes, an aneurismal sac, the size of a large pea, was



seen springing from the anterior communicating artery and partially embedded in the contiguous brain substance, which was a little lacerated. When removed and washed, the sac was found to arise by a small orifice from the anterior communicating artery close to the right anterior cerebral. It was full of dark blood, and had ruptured at the lower surface, the rent being about two millimetres in length. The hemorrhage had extended along the sheaths of the optic nerves to the eyeballs. The other cerebral vessels were healthy. There was no heart disease.

Reviews and Notices of Books.

A Practical Treatise on Diseases of the Skin, for the Use of Students and Practitioners.—By James Nevins Hyde, A.M., M.D., Professor of Skin and General Diseases, Rush Medical College, Chicago, Ill. 8vo., pp. 572. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Bros.

Truly it may be said that this is the age of hand-books and manuals, written for students and practitioners. These latter have now, when entering on the study of any subject, many works to select from. Five or ten years ago it was the "busy practitioner" for whom short treatises were written—this suppositious individual was evidently too "busy" to read books, and so wisely did not buy them. Now the student-practitioner is appealed to. Dr. Hyde has succeeded in writing a very useful and readable book, and has availed himself of the work of many writers on skin diseases, his indebtedness to whom he always properly acknowledges. The author dedicates his book to Prof. Kaposi, from which it will be readily inferred that he belongs to the Vienna School of Dermatologists, and is not one who believes much in the constitutional treatment of skin diseases. After an opening chapter on the anatomy and physiology of the skin, beautifully illustrated with cuts from Dr. Heitzmann's work on Microscopic Morphology, chapters on general symptomatology, general etiology, general diagnosis, prognosis and therapeutics follow. The author's classification is a slight modification of Hebra's, which is perhaps the best we have yet had. Dr. Hyde is a devout follower of Hebra, and with him scoffs at the idea of eczema ever being a constitutional disorder, and so altogether discourages constitutional treatment. The first thing he advises in its treatment is the *exclusion of all sources of irritation.* This necessitates, he goes on to say, the withholding of all internal medicaments which are harmful. We agree with much of what the author says (which is really only a repetition of Hebra); but we also believe that many cases of eczema are of constitutional origin. Why is it that

eczema in children is so frequently accompanied by constipation, and that local treatment does but little till this disorder is removed? The author wisely draws attention to the fact that in acute eczema the skin will rarely tolerate medicated ointments, and yet how almost universally these are prescribed. Dr. Hyde ranks the preparations of tar in the treatment of psoriasis above chrysophanic acid; certainly in our experience the chrysophanic acid cures much more rapidly and quite as surely as tar. He also believes that arsenic should only be given in this disease "after it fails to respond to other treatment." The work closes with a short account of the syphilo-dermas and parasitic diseases. When speaking of scabies, the author mentions that it is a rare disease in America, and that the cases seen are usually among the newly arrived immigrants. This agrees with our own experience. Lately we have seen but one or two cases in as many years; but formerly it was not uncommon among the French-Canadians. As the work is intended for a text book, of course there is no claim to great originality, and no new theories or ideas are advanced; but the various diseases of the skin are described in a systematic manner in good language. We can honestly recommend it to any one who wants a work on skin diseases, based on the principles of the great Vienna School of Dermatology, as created by Hebra. It is concisely and pleasantly written, and profusely illustrated with well executed wood cuts. The printing and the paper are of the best.

Early Aid in Injuries and Accidents.—By Dr. Friedrich Esmarch, Professor of Surgery at the University of Kiel, etc. Translated from the German by H.R.H. Princess Christian. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Bros.

We here have published a little collection of lectures by Prof. Esmarch to the "Samaritan School" of Kiel; and they well deserve to be widely known and extensively circulated. The need for instruction to the general public in the elements of the principles to guide one in the commoner surgical emergencies has long been fully recognized. Attempts have in this city, as

elsewhere, been made to supply this knowledge by means of popular lectures and demonstrations upon these subjects. A short handbook of this kind will prove an excellent adjunct. Prepared by that best-known of Continental surgeons, Esmarch, (whose name has even been turned into a household *verb* in Hospitals), it furnishes exactly the information that will be sought for. After a short introduction concerning the structures of the body and their anatomy in a general way, separate chapters are devoted to injuries (contusions, wounds, etc.), fractures, dislocations, sprains, etc. Then frost bite, drowning, poisoning, etc., and lastly a lecture on transport. A number of figures are introduced for the better explanation of the text. All physicians will do well to bring this book to the notice of their clients to be perused, and to be referred to when occasion requires. The ladies will take a special interest in its circulation from the fact of the translation having been made by an illustrious lady who has shown such a noble example in all good works.

The Compend of Anatomy, for Use in the Dissecting Room, and in Preparing for Examinations.—By John B. Roberts, A.M, M.D., Lecturer on Anatomy and on Operative Surgery, in the Philadelphia School of Anatomy, etc., etc. Third Edition. Philadelphia: C. C. Roberts & Co.

This small book of pocket size seems to be appreciated by those for whom it is intended, and we believe it is as good and complete as any of the others gotten up for similar purposes. We do not recommend the use of these abbreviated aids, for they chiefly assist the cramming process; but as some will have them, better they should be of good quality, such as the above.

The Laws of Life and their Relations to Diseases of the Skin.—By J. L. Milton, Senior Surgeon to, and Lecturer at, St. John's Hospital for Diseases of the Skin. London: Chatto and Windus, Piccadilly.

This little book, which comes to us in cheap pamphlet form, consists of a series of lectures delivered by Mr. Milton at St.

John's Hospital. They are philosophical, and deal with the waste and repair of the human body from a scientific standpoint. The discussions on these all-important matters lead up to that on the bearing of these upon the nutrition and maintenance of healthy conditions in that valuable emunctory, the skin. The original manner in which the various subjects are treated of will claim attention and excite interest, even though every statement should not be accepted without question. A perusal of these lectures cannot fail to furnish food for thought, and to throw light upon some dark places in the pathology of the skin.

"Braithwaite's Retrospect."—Vol. LXXXVI. July-Dec. 1882.

Comes to hand in the usual form. It is compiled just as carefully as ever, and contains all the new discoveries and all the most valuable papers of the latter half of the past year. Every one should be a subscriber to *Braithwaite.*

Manual of Gynecology.—By D. Berry Hart, M.D., F. R. C. P., Lecturer on Midwifery and Diseases of Women, School of Medicine, Edinburgh, etc., etc.; and A. H. Barbour, M.A., B.Sc., M.B., Assistant to the Professor of Midwifery, Univ. of Edinburgh, etc. Vol. I. With eight plates, and one hundred and ninety-two wood cuts. New York: Wm. Wood & Co.

The above forms the volume issued with Wood's Library for the month of January. This special branch, now rising so rapidly in the estimation of the profession at large, has been carefully attended to in the "Medical Library" series. The present work is an admirable addition thereto. Its principal feature is the prominent position given, and the extended space devoted to the physiology and pathology of the important female organs of generation. The most recent researches on the various points connected with these subjects are fully entered into and made the foundation of all the clinical teaching which follows. The matter has been compiled with great care and, whilst complete, yet conciseness is never lost sight of. Illustra-

tions are introduced in great profusion, the plates being very well executed, and the woodcuts of superior quality. Several of the figures are from actual sections—frozen and otherwise—which, for certain purposes, are indeed the only ones which can be accepted as reliable.

Books and Pamphlets Received.

Experimental Pharmacology: A Handbook of Methods for Studying the Physiological Action of Drugs. By L. Hermann. Translated by Robert Meade Smith, M.D. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Bros.

The Systematic Treatment of Nerve-Prostration and Hysteria. By W. S. Playfair, M.D., F.R.C.S. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Bros.

Student's Guide to the Diseases of the Eye. By Edward Nettleship, F.R.C.S. Second Edition. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Bros.

A System of Human Anatomy, including its Medical and Surgical Relations. By Harrison Allen, M.D. Section IV. Arteries, Veins and Lymphatics. Philadelphia: H. C. Lea's Son & Co. Montreal: Dawson Bros.

Trichinæ: their Microscopy, Development, Death, and the Diagnosis and Treatment of Trichinosis. By W. C. W. Glazier, M.D. The Illustrated Medical Journal Company, Detroit, Mich.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, February 16th, 1883.

T. G. Roddick, M.D., Vice-President, in the Chair.

Case of Aneurism of Anterior Communicating Artery.—Dr. George Ross narrated the case. (*See page* 548.) Dr. Ross remarked on the difficulty of diagnosing the case at first, and of the assistance rendered by the development of subconjunctival ecchymoses. In his experience this was a very rare occurrence in cerebral hemorrhage.

Dr. Osler called attention to the fact of the frequency of aneurism of the cerebral vessels, and to the fact that many cases of apoplexy in young persons were caused by them. This was the eighth instance which had come under his observation in the past few years, and all the specimens had been shown at the Society. Of these, four were of the middle cerebral artery,

two of the basilar, and two of the anterior communicating. In seven of them, death was caused by rupture of the sac. He remarked that in cases of fracture of the sphenoidal bone, or in instances such as this, where the hemorrhage occurred in the neighborhood of the optic nerves, the subconjunctival hemorrhages would be more common ; but when the fracture was in the middle or anterior part of the orbital plate of the frontal, the hemorrhage was into the more superficial parts of the orbit, and more likely to produce ecchymosis of the lid.

Ulcerative Endocarditis, simulating Typhoid (with specimen). Dr. Geo. Ross related the case ; that of a man, aged 26, admitted to the General Hospital on the 2nd in a state of delirium, with temperature 104°F., pulse 100, respiration 28. Though delirious, he would at times answer questions. Face was flushed, eyes bright, pupils small ; expression nervous and anxious. Tongue dry, cracked, and brown ; abdomen full ; marked tenderness in right iliac fossa ; no rose spots. Examination of heart and lungs revealed nothing abnormal. The following history was obtained : Had never been very sound in mind, but has been healthy ; was at work on January 29th, when he was taken with a severe chill, followed by headache, vomiting, and nausea. Went to bed that evening ; became delirious, and has been feverish, with severe headache, ever since. There have been several loose stools each day. On the night of the 2nd he was very delirious, talking loudly, and getting out of bed. Passes fæces and urine involuntarily. On the 3rd the temperature was 102° ; pulse 125, and weak. On the 4th, after a very bad night, the patient was much quieter, dull and stupid ; face dusky ; can get no reply to questions ; temperature 103°, pulse very weak ; passed stools in bed. Patient gradually sank, and died on the next day—the third after admission, and the eighth of his illness. The heart and kidneys were exhibited. The autopsy showed extensive ulcerative disease of the aortic valves, two of which had fused (congenital), and were sclerotic. The vegetations were soft and recent, and there was a small perforation of one segment. The mitral valve was unaffected. The spleen was about twice the normal size, but presented no infarctions. The kidneys were

enlarged, and showed six or eight recent infarctions. In the small intestine there were half a dozen spots of hemorrhagic infiltration of the submucosa, the centre of each occupied by a small white necrotic patch (infarctions). In the left occipital lobe there was a spot of recent red softening, the size of a small apple. No other foci in the brain.

Dr. Ross stated that he had thought the case one of typhoid fever from the mode of onset and the pronounced abdominal symptoms. The only suspicious features had been the bright eye and injected conjunctiva, and if a murmur had been heard a correct diognosis might have been reached. The experience of a considerable number of cases had now made both physicians and attendants at the General Hospital tolerably alive to the subtleties of this disease, but in none of the previous ones with typhoid symptoms had the course of the disease been so rapid.

In reply to a question by a member, Dr. Ross remarked that the state of the valves was certainly such that a murmur might have been expected, but none was heard when he examined the patient the day after admission. The condition of the vegetations would almost prevent a regurgitant murmur.

Dr. Osler exhibited the characteristic micrococci of the vegetations, stained with aniline blue. In this instance there were a few bead-like chains such as had been noted by some writers. Their relation to the disease was still in dispute. They are found in the simple warty vegetations and in the outgrowths often met with in old sclerotic valves; indeed, they appear elements common to various endocardial processes which have very different symptoms and arise under different conditions. Valves which are malformed, as in this instance, appear specially prone to be attacked with this form of the disease.

Calcification of the Tooth-Pulp.—Dr. Osler showed, for Dr. Lovejoy, the section of a first molar with the pulp calcified. The tooth was large and not decayed, but was at times so painful that it was thought advisable to extract it. The cavity was filled with a mass of stony hardness, darker than the dentine, but having much the same appearance. A narrow space separated it from the wall of the cavity. In some animals the pulps become con-

verted into secondary dentine, and in old people progressive calcification is not uncommon. In this case the man was vigorous, middle-aged, with good teeth.

Chylous Ascites.—Dr. George Ross showed a bottle of milky-looking fluid which had been removed from the peritoneum of a lad under his care, who had albuminuric anasarca. The abdomen was much distended, and several pints of fluid were removed. There were no formed elements in the fluid.

Diseased Placenta.—Dr. Gardner exhibited a diseased placenta from a patient who last menstrated on the 12th of August, quickened two days before Christmas, and was delivered of a dead macerated fœtus on the 7th of February. The specimen was much shrunken, measuring about eleven centimetres in diameter and one centimetre in thickness. In general the substance was much paler and firmer than that of the normal placenta. There were a number of firm nodules, evidently the result of placentitis or of extravasated, decolorized, and organized blood-clot, according to the views variously held by authorities on the subject. Interspersed between these nodules were a number of cavities, varying in size from a cherry to an almond, filled with recent blood-clot. The membranes were opaque and very friable, a large part remaining in the uterus and requiring introduction of the hand for its removal after the expulsion of the placenta. The patient is the mother of five children, all born at full term after normal pregnancies. During the pregnancy in question she had been œdematous to a slight extent, had suffered from a feeling of general weakness and craving appetite. When first seen by Dr. Gardner, four days before her delivery, she was suffering from violent headache of the frontal and vertical region, evidently of uræmic character, as there were distinct general anasarca and slightly albuminous scanty urine. For nearly three weeks the fœtal movements had become gradually more feeble, and during the last three days had entirely ceased. At the same time that the movements ceased, the uterine tumor sank towards the pelvis, and had lost its normal elastic feel. Fœtal heart-sounds were inaudible. The headache appeared at the same time as the cessation of fœtal movements and collapse of the

uterus, with renal insufficiency. The fact seems to bear out the pressure theory of uræmia in pregnancy. The treatment before labour consisted in purgative doses of compound jalap powder, with full doses of bromide of potassium and chloral. As the latter gave no material relief to the headache, it was soon discontinued, and 15 minim doses of Battley's sedative solution of opium substituted, with marked success. After the uterus was emptied, the urine increased in quantity, the headache disappeared, and, with the exception of a slight attack of pleurisy, the patient made a good recovery.

Apoplexy into the Ventricles.—Dr. Armstrong mentioned the case ; a man, aged 37, who had consulted him with severe headache, slight intolerance of light, and vomiting. Patient was under treatment for secondary syphilis. In a few days he felt better and was able to go out. On Saturday, the 3rd, he took supper in the evening, but vomited it, complained of great pain in the head, became comatose, and died at 11 o'clock. A *post-mortem* revealed extensive hemorrhage into the lateral ventricle, and the blood had also passed into the fourth. The walls of the lateral ventricle were unbroken, and the source of the hemorrhage undetected.

Puerperal Septicæmia treated by Iodoform Suppositories.—Dr. Alloway presented the records of six cases of puerperal septicæmia, three of which had been treated by a new method, viz., the introduction into the uterine cavity of iodoform suppositories. (*See page* 526.)

Discussion.—Dr. Trenholme thought the practice a reasonable one. He had had no experience with the remedy ; indeed, he was one of those fortunate ones who have never had a case of puerperal septicæmia in private practice.

Dr. Gardner had used iodoform in lacerations of the vulva and perineum with advantage. The tenacity with which it adheres to raw surfaces, and even remains after injections, is a point in its favor. He had used it also in chronic endometritis, and, although it had diminished the pain, no permanent good resulted. He had been in the habit for some time of rendering sponge tents antiseptic with iodoform.

Dr. George Ross referred to diphtheria of the vagina after delivery, and remarked upon its insidious onset in a case which he had treated. He thought Dr. Alloway's suggestion very valuable, and could speak of the benefit he had seen follow in one extremely severe case of puerperal septicæmia. The fetor was removed, and a decided improvement manifested within 48 hours. He did not think there was any danger of toxic effects in the doses mentioned.

Dr. Cameron spoke of the great influence of iodoform in subduing pain, but believed the special advantages in this form of treatment were the constant presence of the antiseptic in the uterine cavity and the certainty that all parts would be subjected to its action. In the cases reported, some of the benefit might reasonably be attributed to the washings, which should not be neglected in any case.

Dr. Armstrong said he unfortunately had had a good deal of experience in these conditions, the treatment of which must in a great measure depend on our theory of their production. In the grouping together of actual facts, as observed by him, he had found them to harmonize very considerably with the division adopted by Matthews Duncan, namely, into cases of *simple sapræmia* and *true septicæmia*. In the former there is absorption of putrid ichor by the lymphatics, or its passage into the circulation through the uterine sinuses ; the poison does not exist in the blood, much less grow and multiply in it, while in true septicæmia the poison is a germ which lives, grows and multiplies in the blood (the discharge in these cases may indeed be not fœtid at all). In the treatment of simple sapræmia, and Dr. Armstrong took this to be the nature of the favorable cases described by Dr. Alloway, the object is to remove the cause as thoroughly as possible, and this can be accomplished by careful cleansing and disinfection of the parts by carbolic acid or other disinfectant ; and it would seem that iodoform possesses advantages over carbolic acid for this purpose, being less troublesome and saving much valuable time to the practitioner, but as to its unfailing efficacy in cases of true septicæmia, Dr. Armstrong thought the reader of the paper was inclined very much to overestimate it.

Dr. F. W. Campbell said he thought the Society indebted to Dr. Alloway for the important cases which he had brought before them. The high mortality from puerperal septicæmia under existing methods of treatment would, in his opinion, warrant a trial of the method suggested by Dr. Alloway, which seemed to have been singularly successful. He thought there was a certain class of cases where it would be well to anticipate, as it were, a condition of septicæmia, as it often supervened. He alluded to cases where there was extensive adhesion of the placenta, and where its removal was attended with great difficulty. In such cases, he thought the introduction of iodoform would be found very useful, not alone in preventing putrefactive changes, but in healing torn surfaces.

Dr. Alloway stated that he had been induced to lay his limited experience before the Society, in the hope that other members would test the practice. For his own part, he felt much more confidence now in the treatment of these cases. In illustration of the antiseptic powers of iodoform, he showed two bottles of meat infusion which had been allowed to decompose ; into one he had put a little iodoform, and the decomposition had been checked, the putrid odor was removed, and the solution rendered (as was very apparent) much clearer by the death and subsidence of the bacteria. In reply to Dr. Armstrong, he would say that the whole subject of septicæmia has been, until quite recently, in well-nigh hopeless confusion. It was, however, now almost universally acknowledged that septicæmia is due to the presence in the blood and tissues of a virus, which virus is *not* a germ or number of germs, but is a product generated by micro-organisms, by certain vital processes and under certain conditions of their surrounding media. These organisms do not arise spontaneously in the blood, but are introduced from without, and are incapable of multiplying in the living healthy tissues. Under certain circumstances they produce a simple uncomplicated paroxysm of fever, beginning with a rigor, followed by a rise of temperature and ending (if the dose be not too large) in defervescence and recovery. And it matters little what classification we use, whether we regard Dr. Matthews Duncan's of simple and true septicæmia, or any other division, they are but graded condi-

tions of one and the same disease, differing only in the degree of severity. If Dr. Duncan maintains that in so-called true septicæmia the poison is a germ, he stands alone in his theory, as widely published experiments prove the contrary; simple cases certainly do occur, and it is probably in this way: the site of the placenta receives infection from septic bacteria; if the discharges are retained in contact with the wound, decomposition sets in, pyrogen is produced, it is absorbed, a toxic effect follows, and septicæmia is established. If we now recognize and are fully alive to the beginning of a serious trouble we will cleanse the uterus of the already-formed virus, and protect the patient from its further formation and absorption. In a few days the patient gets well, and she is said to have had an attack of simple septicæmia. But let us not recognize the importance of arresting this toxæmia, and content ourselves with occasional antiseptic washings; there is continuous absorption, occasionally interrupted for a few minutes by the washings, the vitality of the system is progressively lowered, and especially the tissues bordering the wound, which become moribund or die right out. The germs invade and breed in them, more poison is produced and absorbed, the toxæmia becomes intense, embolic centres of inflammation are formed, and the end comes. This is probably Dr. Duncan's true septicæmia, but which is really the result of failure of the remedial agents used in the treatment, and on post-mortem section we find the channels and cavities of the body swarming with bacteria. It will be remembered that the fatal case Dr. Alloway mentioned in his report began in this simple way: there was an accumulation of discharge arrested in the inflamed womb (endometritis), germs found in this discharge a suitable soil for the generation of virus, and this not having been interfered with death took place. The second case treated by iodoform suppositories began in identically the same way (severe peri-uterine pain and chills), but was arrested in the way he had explained, through the agency of iodoform. The other two cases treated with iodoform were the result of dead children having been borne to them; and as the history of such cases, when sepsis sets in, is very often death under any circumstance, he does not think they deserve to be looked upon as

simple. Dr. Alloway concluded by saying that his remarks referred to septicæmia as met with in private practice, and not to those epidemics which have prevailed in large lying-in hospitals, or to those rare cases of intense poisoning where the cause of death is more shock than gradual poisoning with elevation of temperature.

Brains of Two Murderers.—Dr. Osler presented the brains of Richards, who murdered a comrade at Sweetsburg, Que., and of O'Rourke, who killed an old man and his daughter, at Milton, Ont. (*See p.* 461, CAN. MED. AND SURG. JOURNAL.)

Dr. Henry Howard said this was the second time in the space of thirteen months that this Society has been favored by Dr. Osler with a demonstration, at each time of two brains taken from the cadavers of criminals, who had been tried for, and found guilty of, murder. The brains before us appear to be of a low type; they may, or may not, be teratological, we cannot tell, because we do not know what constitutes a normal brain. There may be pathological defect in these brains, neither macroscopical nor microscopical but ascopical, we cannot tell. When we know the anatomy of the normal man, surgically and chemically, more particularly of the whole nervous system—which we do not now know; when we know the physiology of all the organs of the normal man, more particularly of the whole nervous system—which we do not now know; when we know the ætiology and pathology of what we call insanity, then, and not till then, will we be able to say what is the pathological defect which is the cause of mental derangement, which we call insanity—meaning thereby a state of mind the opposite to sanity. Under existing circumstances we have but little to guide us more than a man's conduct; and when we see a man an habitual criminal, and committing such terribly unnatural crimes as murder, we know that such a man is not as other men that are non-criminals, and we must assume that he is what he is in virtue either of teratological or pathological defect in his mental, which includes his intellectual, organization. We assume this for the following reasons: first, that we do not find men of normal minds, normal intelligence, guilty of these crimes; secondly, that as mind and its phenomena is one of the qualities or properties of matter with

which the Creator endowed it, and the higher the degree of organic, animal matter—matter in the concrete—the higher is mind and its phenomena developed. Therefore, when we find a man to be a murderer, we must assume that he is such in virtue of an abnormal state, teratological or pathological defect, of his mental organization. From the history of the two men whose brains are now before us, I come to the conclusion that the man Richards labored under teratological, and probably pathological, defect of his mental organization; and I consider it quite possible that the latter, being an inebriate, and having drunk a quantity of whiskey that day, committed the crime while in a somnambulistic, not drunken state, and afterwards, forgetting all about it, accused another of the crime.

Provincial Health Act.—Dr. Larocque, the Health Officer of the city, called the attention of the members to the Act now before the Legislature, and gave a sketch of the progress which had been made during the past few months. The Act provides for the establishment of a Board of Health for the Province, to be composed of three medical men, three commissioners, and one sanitary engineer. He urged the members to do all in their power to get the bill passed this session.

PROVINCIAL MEDICAL BOARD.—The semi-annual meeting of the Board of Governors of the College of Physicians and Surgeons of the Province of Quebec will be held on Wednesday, the 9th of May, at 10 A.M., in the Laval University, Montreal. Candidates for examination or for license must send their papers (including certificate of admission to the study of medicine), also the fee for the license, $20, *at least ten days previous to the meeting*, to either of the secretaries, A. G. Belleau, M.D., Quebec, or F. W. Campbell, M.D., Montreal. Candidates for the license must be present and have their diploma with them.

PROVINCIAL MEDICAL BOARD.—The preliminary examination for admission to the study of medicine will be held on Thursday, the 3rd of May, at 10 A.M., at the Laval University, Montreal. Certificates of moral character and the examination fee, $10, must be remitted *at least ten days previously* to one of the secretaries.

CANADA

Medical and Surgical Journal.

MONTREAL, APRIL, 1883.

THE NEW ANATOMY ACT.

On the 1st instant there came into force the Provincial Act "to amend and consolidate the various Acts respecting the study of Anatomy." It is a new departure in the way of legislation for the prevention of body snatching, and if faithfully carried out will, it is to be hoped, prove effectual. As it is very important that all members of the profession in this Province should be acquainted with the provisions of this Act, we shall draw attention to the various sections of which it is composed. The Province is first of all divided into two sections, the "Quebec Section" and the "Montreal Section," which shall comprise such judicial districts as may be specified by the Lieutenant-Governor. Then, the Lieutenant-Governor is to appoint an Inspector of Anatomy for each of these sections, and a Sub-inspector of Anatomy for each judicial district except those of Quebec and Montreal, at which places the Inspectors themselves act as such. The next section provides that every unclaimed body in institutions receiving Government aid shall be delivered, through the Inspectors, to the different schools of medicine. To prevent such action a claim for the corpse must be made inside of twenty-four hours of the person's death, by a relative within the degree of cousin-german. All superintendents or directors of institutions with public grants, and all coroners, are obliged to immediately notify the Inspector or Sub-inspector of their being an unclaimed corpse under their control. Provision is made that the Inspectors keep registers of all such notifications received; that they impartially distribute to the schools of medicine the corpses thus received, in proportion to the number of their students; and that they inspect

the dissecting rooms and order the decent interment of the remains. The Inspector is to receive $10 for each body so supplied, in addition to cost of transport and burial. A fine of from $100 to $200 is imposed upon any superintendent of the above named institutions who fails to notify as provided in the Act; and a similar fine is laid upon any school of medicine which shall be found to have received and used for dissection any body not procured through the Inspector. The Inspector or Sub-inspector is bound to appear within eight days before the *curé*, or clergyman, of the parish wherein has occurred the death of any unclaimed person, and to make an entry on the death-register of the date of death, etc., and of the manner of disposition of the body. All previous Acts are repealed.

We believe this law will work well, will provide an ample supply of dissecting material to all the schools, and at the same time put a stop to the disgraceful desecrations of graveyards and vaults, which have of late become so common. The principal defect in all previous acts, and which we have had occasion several times to point out, has been the absence of any penal clause with reference to non-notification of the existence of unclaimed bodies in our public institutions. A very false feeling on this subject has long existed amongst the directors of several of these establishments; but we trust that now that their attention is strongly directed towards the necessity of their performing this public duty, they will loyally comply with the terms of this enactment. It only remains for the Government to make judicious appointments of the persons to fill the important post of Inspector, and we hope that these officials will at once enter vigorously upon the performance of their public functions, and with impartiality—without fear, favor or affection—see to it that the intentions of the law are carried out in every institution in the Province which gets a grant from the public purse. On the other hand let the schools of medicine accept cordially the legislation thus effected in their best interests; let them insist upon their rights as defined by the law, whilst at the same time refusing to countenance in any way the illicit traffic in bodies which has hitherto prevailed, only through the incompetency of officials and the refusal of responsible persons to furnish the

assistance they will now be obliged to give. Let both parties concerned in this matter unite to put this Act fairly into operation, and body-snatching will soon be numbered amongst the lost arts.

LAVAL VICTORIOUS.

There has been quite a stir in the medical circles here, and especially amongst our French-Canadian *confrères*, concerning the final decision in the long-standing dispute between the Laval and Victoria Universities. The Supreme Head of the Catholic Church has decided that Laval shall be supported, and calls upon the members of Victoria School, as well as all the faithful throughout the Province, to cease all opposition to that which must now be recognized as *the* Catholic University to be, and, instead, to give it all the assistance possible towards increasing its power and extending its influence. This, of course, applies to the *succursale* already established in the City of Montreal. Canadian Catholics are noted for their strict ecclesiastical obedience. Not a word of dissent, therefore, has been, or is likely to be, heard, now that the Head of the Church has spoken *ex cathedrâ*. The Faculty of Medicine of Victoria University, the latter being a Protestant Institution, must cease to exist. Its suicide must be cheerfully accomplished, not a murmur must betray unwillingness. Rumors as to what is to follow are numerous, but it is difficult to obtain reliable information. It is, however, generally believed that the body which has hitherto constituted the Faculty of Victoria will be re-organized as an independent teaching body, as under the charter of the old Montreal School of Medicine. Others have it that an affiliation is to be effected with the Catholic University of St. Joseph, at Ottawa. The papal decree would prevent all the teachers of Victoria College from holding appointments in the Hotel Dieu, which is the property of the nuns; but, no doubt, the severance of all connection with the objectionable Protestant establishment will allow of their continuing attendance as heretofore. It will be interesting to see whether the old school will submit to being thus wiped out, or whether they will fight any longer for a separate existence.

To persons unacquainted with the mediæval condition of this Province, as regards educational and many other matters, it must indeed seem strange that a single word from Rome is capable of instantly smothering all discussion, and deciding for the rising generation of doctors to whom they shall go for their medical education. It is now sinful for a Catholic student to attend a Protestant University.

MONTREAL GENERAL HOSPITAL.

The resignation of Dr. Wright leaves an important vacancy on the surgical staff of the Montreal General Hospital, which the Governors will be called upon to fill at the annual meeting in May. The division of the wards into medical and surgical, made two years ago, has already been productive of much good, securing to the patients a closer and more skilled attention, and to the students more systematic and thorough teaching. The choice of a man to occupy a position on the active surgical staff of the Hospital should receive the careful attention of every Governor; if judicious, it means an increase in the sphere of usefulness of the institution, the development of another surgeon to add lustre to the city, and the maintenance of the reputation of the Hospital as a teaching centre. Of the candidates for the position of whom we have heard, one we think has a record which should render him very acceptable to the Governors, viz., Dr. F. J. Shepherd. He has served for four years on the out-door staff, doing—by arrangement with his colleagues—surgical work alone, and is looked upon by the profession as one of the rising surgeons of the city. With a reputation as an anatomist, unequaled in the country, thoroughly versed in British and foreign surgical literature, and a skilful operator, he will be a real acquisition to the staff. We have not heard that any other members of the out-door staff are candidates. For the possible vacancy on the out-door board there are several competitors, Drs. R. L. MacDonnell, A. D. Blackader, W. H. Burland and possibly others.

MEETINGS OF CONVOCATION.

McGill University.

The annual meeting for conferring of degrees in the Faculty of Medicine was held in the William Molson Hall, on Saturday, 31st March, the room being crowded with students and friends of the University.

Professor Howard, Dean of the Faculty, read the following list in the Faculty of Medicine:

The total number of students enregistered in this Faculty during the past year was 188, of whom there were from Ontario, 93; Quebec, 44; Nova Scotia, 7; Manitoba, 3; New Brunswick, 15; Prince Edward Island, 9; Newfoundland, 2; West Indies, 2; United States, 13.

The following gentlemen, 42 in number, have passed their Primary Examination on the following subjects: Anatomy, Practical Anatomy, Chemistry, Practical Chemistry, Materia Medica and Pharmacy, Institutes of Medicine, and Botany or Zoology:

Allan, J. H. B.
Arthur, R. A.
Baird, T. A. D.
Barrett, J. A.
Burrows, F. N.
Cassidy, G. A.
Darey, J. H., B.A. (McGill).
Daly, W. D., B.A. (St. Mary's).
Eberts, D. W.
Ferguson, W. A., B.A. (McGill).
Finley, F. G.
Groves, W.
Hallett, E. O.
Hanna, A. E.
Harkin, Fred.
Hurdman, H. T.
Hutchison, J. A.
Irvine, R. T.
Johnson, C. H.
Johnson, H. D.
Joliffe, J. H., B.A. (Union).
Klock, W. H.
Landor, T. H.
Merritt, D. P., M.A. (McGill).
McCormack, N.
McClure, W., B.A. (McGill).
McGannon, M. C.
McKenzie, J. T.
McLellan, J. H.
McMillan, D. L.
O'Brien, T.
Osborne, A. B.
Park, James.
Powell, F. H.
Robertson, A. M.
Ross, L. D.
Ruttan, R. F., B.A. (Toronto).
Scott, J. M.
Sharp, I. C.
Shibley, J. L., B.A. (Victoria).
Trapnell, H. E.
Wilson, J. A. K.
Wood, Ed. G.

The following gentlemen, 30 in number, have fulfilled all the requirements to entitle them to the degree of M.D., C.M., from the University. These exercises consist in examinations, both written and oral, on the following subjects: Principles and Practice of Surgery, Theory and Practice of Medicine, Obstetrics and Diseases of Women and Children, Medical Jurisprudence and Hygiene, also Clinical Examinations in Medicine and Surgery, conducted at the bedside in the Hospital:

Allan, Clarence E.
Bowser, James C.
Cameron, Chas. E.
Carruthers, George.
Dearden, George A.
Gardner, John J.
Gray, James.
Hanvey, Chas. B. H.
Harrison Henry J.
Henry, Wm. G.
Hopkins, Alf. J.
Johnson, Jonathan R.
Lathern J. Simpson.
Loring, J. Brown.
Maher, J. J. E.
Martel, Ovide.
McLeod, Arch., B.A., (McGill).
MacNeil, Alex.
MacLean, John W.
McDonald, Alexander.
Muckey, F. S.
Phippen, Samuel S. C.
Ross, Wm. K.
Rutledge, And. J.
Scott, Walter McE.
Shaver, Wm. H.
Sihler, George A.
Stewart, Andrew.
Struthers, Robt. B.
Wood, Edward S.

MEDALS, PRIZES AND HONORS.

The Holmes Gold Medal for the best examination and final branches was awarded to C. E. Cameron, of Montreal.

The Prize for the best Final Examination was awarded to J. Brown Loring, of Sherbrooke, Q.

The Prize for the best Primary Examination was awarded to Edwin G. Wood, Londesboro, O.

The Sutherland Gold Medal was awarded to R. F. Ruttan, B.A., Napanee, O.

The following gentlemen, arranged in the order of merit, deserve honorable mention:

In the Primary Examination Messrs. R. F. Ruttan, B.A., W. A. Ferguson, B.A., J. H. Darey, B.A., F. G. Finley, H. E. Trapnell, H. T. Hurdman, T. A. D. Baird, F. N. Burrows, M. C. McGannon, and Fred. M. Harkin.

In the Final Examination Messrs. Struthers, Lathern, Bowser, Gray, Carruthers, Gardner, Henry, Scott and J. R. Johnson.

PROFESSORS' PRIZES.

Botany.—Prize: Chas. W. Wilson, Cumberland, O., and J. A. Kinloch, Montreal.

For the best Collection of Plants.—H. E. Trapnell, Harbor Grace, Nfld.

Practical Anatomy.—Demonstrator's Prize: 2nd year, F. G. Finley, of Montreal; 1st year, A. L. Howey, Eden, O.

Morbid Anatomy.—James Gray, of Brucefield, Ont., and C. E. Gooding, of Barbadoes, W. I.

Dr. I. Brown Loring then delivered a very suitable valedictory on the part of the class, and Prof. Girdwood addressed the graduates on behalf of the Faculty. (*See page* 520.)

The Dean of the Faculty, briefly addressed the Convocation as follows:—It affords me much pleasure to state, for the information of the friends of medical education, that the efforts of the Faculty to raise a "Campbell Memorial Fund" are likely to be successful. Owing to the numerous calls upon our time during the winter session, my colleagues and myself have as yet seen but a portion of the many friends of our late highly esteemed Dean and of our Faculty, and they have been so generous that we confidently expect to collect the sum that we want with a view of commemorating the memory, and worth, and work of our late Dean, Dr. Geo. W. Campbell, in an appropriate way, and in some degree commensurate with the high qualities of the man. In the introductory lecture of this our fiftieth session, some of the many uses to which a very much larger amount could be most profitably put in the interests of medical education were mentioned, and I do not purpose to reproduce them now. It appears fitting, however, that we should inform our friends and the public generally that as a medical school we are steadily improving and extending our means of instructing and training students in both the science and art of medicine. The admirable system of bedside instruction, inaugurated a few years ago, is not only efficiently and zealously maintained by the Professors of Clinical Medicine and Surgery during the winter session, but is continued throughout the summer months by the Professors of Systematic Surgery and of the Institutes of Medicine. The method of teaching the classes is yearly becoming demonstrative where it formerly was largely or solely oral and pictorial, and practical instruction and demonstrations are given in Physiology, Histology, Morbid Anatomy, Chemistry, in Obstetrics and the Diseases of Women. The advantages of this method are shown by the steadily increasing number of students attending the classes and the interest they take in their work. The time devoted to systematic teaching was, eight years ago, extended to nine months annually by the establishment of a summer session of three months duration, during which short courses of lectures upon special departments or subjects of medicine and surgery are delivered; and clinical and practical instruction form prominent features of these sum-

mer sessions. The number of men attending them increases every year, and, although not compulsory, it is quite the exception for a student to proceed to his degree in medicine who has not attended one or several of these summer sessions. Within the present month a Demonstrator of Physiology and Histology in connection with the chair of Institutes has been appointed by the Governors, and the gentleman who has efficiently assisted the Professor of Physiology in doing that work for the last two years received the appointment, and has already gone for six months' additional preparation in the laboratories of Germany. These are some of the evidences that I would adduce to show that the Medical Department of our University is alive and active, and not disposed to rest satisfied with what has been done in the past by the able men who have retired or been taken away from their work. And it is with the view of enabling it to carry on the present work more efficiently, as well as to enlarge it in one or two important directions, upon which I should like to speak, were you not already overdosed with medicine, that the Medical Faculty is now appealing to its friends to found a "Campbell Memorial Fund" worthy of the man, of the work, and of the friends of both.

Trinity Medical School, Toronto.

First Class Honors.—First year scholarship: Stuart Scott. Second year scholarship: Robert Lucy; Angus Graham, James Johnston (equal); Charles M. Sandford, Clark Lapp and W. H. McKeague (equal); and John A. Symonds.

Second Class Honors.—J. McD. Cleminson, D. C. Throop, G. J. Dickison, E. M. Féré, W. V. Lynch, Woodhull, E. Hooper, Doolittle, N. Allen, J. E. Midgley, Stacey, Holmes, Charlesworth, Soden, W. H. Hay, Baumann, H. W. Thompson, W. A. Williamson, Housberger, Roberts, Mackenzie, Darrell, Haultain, Mr. A. C. Woodley in anatomy and physiology.

Passmen.—A. B. Lang, O. Totten, F. McAllister, C. Abbott, J. G. Harper, L. Brock, Jonn Evans, J. A. McLeay, J. T. Bell, J. J. Cassidy, L. F. Cutten, F. Brown, A. B. Eadie, Robt. West, L. W. Thompson, J. C. McCabe, George Veitch, Thos. Wilson, W. S. Airth. Mr. A. Gillespie passes in botany, practical anatomy and physiology.

PRIMARY EXAMINATION.

First Class Honors.—Second year scholarship: J. R. Logan Wm. Brown, H. H. Hawley, S. H. Mott, C. F. Snellgrove, P. A. Dewar, S. A. McKeague and Robert Owens.

Second Class Honors.—G. A. Bingham, D. O. R. Jones, F. Campbell, W. H. Pebler, G. L. Airth, T. Owens, J. M. Cochran, W. E. Sprague, G. J. Paul, T. McCullough, A. B. Wilson, G. Fierheller, J. Lindsack, H. D. Leach, A. T. Little and R. J. Lochart.

Passmen.—P. H. Salter, J. S. McCullough, J. E. W. Anderson, T. M. Lawton, J. A. Couch, J. Park, C. J. McIntyre, J. C. Bell, J. Johnston, A. Gillespie, J. E. Brown, A. V. Delaporte, W. J. Chambers, D. W. Carmichael, A. E. Stuart, A. McKillop, C. Trow, J. G. White, R. C. Coatsworth, F. C. Hood, Duncan Gow, A. K. Sturgeon, P. M. Davey, J. D. Davidson, E. Framer and S. M. Dorland passed on certain subjects.

FINAL EXAMINATION.

J. E. Jenner, Trinity School, gold medallist; B. H. Scott, first silver medallist; E. M. Hoople, second silver medallist; McConochie, T. H. Robinson, Backus, A. Hawke, certificates of honor.

The following gentlemen have passed: S. W. Lamoreaux, T. D. Meikle, R. Hislop, D. F. Rae, Dickson, J. H. McCullough, T. C. Cowan, C. E. B. Duncombe, R. M. Fairchild, J. A. Thompson and G. J. Charlesworth.

VICTORIA COLLEGE, MONTREAL.

Final Examination.—Messes Omer, Allard, Alf. Archambault, J. A. Bigonenesse, Joseph Bastien, Aug. Brion, J. U. Brisbois, J. P. Chartrand, Sidney Craig, J. S. Chagnon, L. J. Camire, Jos. Chaiffers, Z. Etue, H. E. Langis, Anthime E. Leclair, G. H. Lacoursiere, H. Mathieu, L. A. Moil, Nap. Morencey, A. Quimet, Ed. A. Poitevin, J. G. Prevost, J. A. Pepin, G. Pelsdeau, Guil. F. Prevost, H. Roman, J. F. Rioux, M. J. A. Salvail, E. Simard, M. A. Seguin, Chas. Tessier, R. Vaillancourt and Geo. N. Wateir.

Primary Examination.—M. M. Lucien Belliveau, George Beaudoin, A. Barolet, F. Guil. Brosseau, Jos. Bastien, A. Brion, Fred. Daignault, F. Dubois, T. W. Fournier, A. P. deGrandpre, H. Gauthier, A Leblanc, G. Peladeau and J. F. Rioux.

BISHOP'S COLLEGE.

Primary Examination.—The following candidates successfully completed and passed their primary examinations, consist-

ing of Anatomy, Physiology, Materia Medica and Hygiene: Ernest E. Bronstorph, winner of the David Scholarship; R. C. Blackmer and C. B. Ball, first class honors; E. O'B. Freligh, second class honors; P. E. Minckler, W. Patterson. Passed in Medical Jurisprudence: F. B. Saunders, W. A. Mackay.

Final Examination.—The following candidates passed the final examinations, consisting of Practice of Medicine, Surgery, Obstetrics, Pathology, Medical Jurisprudence, Clinical Medicine and Clinical Surgery: J. A. Caswell, Wood Gold Medal; E. Sirois, Chancellor's Prize; P. E. Minckler.

Obituary.

Dr. VanBuren.—American surgery has lost one of its ablest and best known representatives in the death of W. H. Van Buren. He was born in 1833, of old Dutch stock, his great-grandfather, a physician, having emigrated from Holland in 1800. He was educated in Philadelphia and Paris, and for a time served as assistant-surgeon in the army. He married a daughter of Valentine Mott, and moved to New York in 1845. For many years he held the chair of anatomy in the University School, and in 1868 was appointed Professor of Surgery in Bellevue. His best known works are upon the *Diseases of the Rectum* and *Diseases of the Genito-Urinary System.* To many Canadian Surgeons he was very well known, and in difficult and obscure cases his advice was much sought after. He was a scholarly man, with a quiet dignified manner, which impressed strangers very favorably.

Dr. Kollmeyer.—The death of this gentleman took place on the 13th ult., after a long and painful illness. He was born in the city in 1832, and educated at the High School; entered the medical faculty, McGill College, and graduated in 1856, his thesis being 'On the Syphilitic Virus.' While a student he was apothecary to the Hospital, and after graduation entered upon practice in the city, and enjoyed the reputation of a careful and skilled physician. For some years he lectured upon Botany and Materia Medica at the College of Pharmacy, and held the chair of Materia Medica at Bishop's College from its establishment. He had the reputation of being a very successful teacher, particularly in Chemistry and Materia Medica, and

for years conducted large "grinding" classes. He edited the Pharmaceutical department of the *Canada Medical Record*, and was an occasional contributor to the journals. In 1875 he published a useful little work, "Chemia Coarctata," which has had considerable sale among students.

Dr. Gascoigne.—His death took place early in February at Jamaica, where he had been in practice for some years. He came to this country as Surgeon in the artillery, and while stationed in Montreal graduated at McGill, '61. He retired from the service and practiced for a time at Brockville, Ont.

Victor Von Bruns.—This celebrated German Surgeon, Director of the clinic at Tübingen, died on the 19th, aged 71. He was a voluminous writer on surgical subjects, especially laryngology. In 1861 he first extirpated, with the aid of the laryngoscope, a laryngeal polypus from the throat of his brother.

—The deaths are also announced of Prof. Sigmund of Vienna, the celebrated syphilographer, and of Dr. Ranney of New York.

Personal.

Dr. Canniff has been appointed Health Officer for the City of Toronto.

Dr. H. Harkin sailed for England by the "Parisian" on the 7th.

Dr. Kennedy has been appointed Registrar of the Medical Faculty, Bishop's College.

Alexander McTaggart, M.D. (McGill '69), has resumed practice at London, Ont.

Dr. Wright has resigned from the active staff of the general Hospital after years of service.

We are glad to hear that Hon. Dr. Schultz has so far improved as to appear in the Senate.

J. A. Grant, Jr., M.D. (McGill '82), has returned from London. He enters practice with his father in Ottawa.

G. W. Nelson, M.D. (Bishop's '79), has been appointed Resident Surgeon to the Central Hospital, Panama.

As we go to press, we hear that Dr. Wright has resigned the chair of Materia Medica and Therapeutics in McGill College.

Ed. S. Wood, M.D. ('83), has gone to British Columbia as assistant on one of the sections of the Canadian Pacific Railway.

Dr. Field, Medical Superintendent of the Asylum at Barbadoes, who has been spending part of his leave of absence in Montreal, left for home on the 27th ult.

Dr. Chas. C. Cameron, the McGill Gold Medallist in Medicine for the year, left on the 7th for a two years' course of study in England and Germany.

Mr. William Saunders of London, Ont,, Professor of Materia Medica in the Western University, has been elected a Fellow of the Royal Microscopical Society of London, Eng.

Henry P. Loomis, son of the well known physician, Dr. A. L. Loomis of New York, received the Prize of for the best Final Examination in the University of New York.

—We regret to see that Dr. J. E. Robertson, M.P., of Montague, P.E.I., has been unseated in consequence of his having omitted to resign his seat in the Local Legislature sufficiently early.

—The well known Surgeon, Prof. McLean of Ann Arbor, has been successful in his action for libel against the Detroit *Evening News*. Damages were placed at $50,000, and the jury gave $20,000.

The death is announced of Dr. Goring of St. Thomas, Ont., at the age of 72. He held the diploma of the R.C.S., Ireland, 1842, and the license of the College of Physicians and Surgeons of Lower Canada, in 1849.

W. R. Sutherland, M.D. (McGill '78), has been appointed one of the Assistant Demonstrators of Anatomy, in McGill College. He left on the 7th to spend six months in the anatomical schools of Paris and Berlin.

Dr. Scott, Prof. of Anatomy, McGill College, is, we regret to say, seriously indisposed, his physicians having detected signs of combined renal and cardiac disease. He has not been quite well all winter, but lectured with his usual vigor, and conducted the examinations on Anatomy at the close of the session.

R. F. Ruttan. B.A., who took the Sutherland Gold Medal and the Morrice Scholarship at the recent Primary Examination in McGill College, is the son of Dr. Ruttan of Napanee, Ont., a McGill alumnus of '52. Mr. Ruttan had a brilliant career at the University College, Toronto, and took the Gold Medal in Natural Sciences.

Dr. Wm. Gardner, Lecturer on Gynæcology in the summer session, McGill College, and physician to the University Dispensary for Diseases of Women, has given up general practice, and will hereafter devote himself exclusively to Diseases of Women.

Dr. Rosebrough of Toronto, the well known oculist, has for some years past devoted much attention to electricity, and there are in the pages of the *Canadian Journal* and *Canada Lancet* many valuable communications from his pen. In conjunction with Mr. Black he has taken out the patent for an exceedingly important invention, whereby telephonic and telegraphic messages can be simultaneously transmitted over the same wire. The practicability of the invention has been tested and its importance admitted.

Medical Items.

—It is reported that Dr. Jenny K. Trout of Toronto, has offered $10,000 towards the establishment of a School of Medicine for women. This, if true, may make the venture possible ; but we still maintain that as yet there is no need for such an institution in Canada.

—Dr. Lawrence Washington, a great nephew of Gen. Washington, who served in the late war on the Confederation side, died recently in England, leaving his family poor in money, but rich in relics of the great general. Among these possessions are several letters and interesting documents, the sabre he used in the revolution, and the silk rep suit he wore at his first inauguration.

—The Student's Journal has the following; "Well, madam, how's your husband to day?" "Doctor, he's no better" "Did you get the leeches?" "Yes, doctor, but he could only take three of them raw; I had to fry the rest."

—A busy doctor sent in a certificate of death the other day, and through accident, doubtless, inserted his name in the blank space for "Cause of Death." Thus do men sometimes blunder into truth.

—Dr. Albert G. Craig. Vevay, Indiana, suggests the substitution of linseed oil for olive oil in the composition of liniments. He has found it better, as well as much cheaper.

CANADA

MEDICAL & SURGICAL JOURNAL

MAY, 1883.

Original Communications.

VIENNA LETTER—SYPHILIS AND ITS TREATMENT.

(*From our Special Correspondent.*)

VIENNA, April 10, 1883.

In addition to several large ambulatoriums, there are 400 beds in the general hospital of this city for the treatment of syphilitic cases. There are three professors in connection with this subject; two ordinary, Zeissel and Neumann, and one extra-ordinary, Auspitz. In addition, there are four privat-docents and six assistants.

Prof. Neumann is the successor of the late Prof. Sigmund. It is principally through the influence and efforts of the latter that Vienna presents such advantages for the study of syphilis. It is to him also that the profession are indebted for the modern and very simple method of classifying the various syphilitic skin eruptions. To many it may appear very strange that a physician should devote his lifetime to the study of a subject that appears when superficially viewed quite plain and simple. There is really however no subject, or group of subjects even, that requires such a general and accurate knowledge of the different scientific and practical branches of medicine as does syphilis. He who wants to know it well must be a good general surgeon, and especially must possess an intimate knowledge of the diseases of the genito-urinary system, and of the skin and mucous membranes. It is necessary also that he should be an accomplished physician, and in particular he should be thoroughly acquainted with the diseases of the nervous system.

In addition, if he wishes to conduct the treatment of his cases in a satisfactory manner, it is necessary that his knowledge of physiological chemistry should be considerable. In fact the general practitioner is the only man in the profession at the present who is truly fitted for this work.

The object of this letter is to give an account of the method pursued in the general hospital of this City in dealing with syphilis in its various stages. The treatment is essentially the same as that pursued by the late Prof. Sigmund. It differs in many points from that followed in England and America, which is that of the French school.

1st. *The Treatment of the Local Sore.*—The term *hard chancre* is now never applied to the local sore, for the simple reason that an infecting sore may be either hard or soft. These qualities do not depend on the nature of the poison, but on the anatomical structures of its seat. Where there is much connective tissue, as in the prepuce, the sore will be hard ; but where there is little of this tissue, as in the glans, the sore is soft. The mineral acids, or the thermo-cautery are never used for the destruction of the local sore. The conclusion has been arrived at, that, after forty-eight hours from the time of infection, treatment of the local sore by escharotics is useless in preventing general infection. It can extremely seldom happen that an infecting sore will be seen by a physician as early as forty-eight hours. The treatment by removing, with the knife or scissors, infecting sores, has been given up here, for it was never found to be of any benefit in preventing the general infection.

The treatment of the chancre is always of the mildest kind. If it is an ulcerating surface iodoform is invariably used, and generally in the form of spray. One part of iodoform dissolved in six parts sulphuric ether sprayed on the surface of the ulcer, leaves a fine coating of the former intimately adherent to all parts of the surface. This method of applying iodoform is much better than simply dusting it on, on account of its adhering to the ulcerated surface better. After a few days use of iodoform, the sore takes on "healthy action," and when the

granulations are healthy, it is no longer advisable to use iodoform, but to employ in its place a 2 per cent. carbolic acid solution When the chancre has healed, and there is left simply a nodule, the best application is one part of corrosive sublimate to fifty parts of water or a diluted mercurial plaster.

2nd. *The Treatment of the Second Stage of the Disease.*— Is it possible to prevent the secondary symptoms of syphilis? This question is answered distinctly in the negative here. It is considered certain that there are no known means dietetic, hygienic or medicinal that can prevent the infection of the system once the local sore has become fairly seated. Sigmund has found, from the observation of many thousand cases left untreated, that in forty per cent. the secondary symptoms are very slight, so slight that in quite a number of the cases they escape the patient's observation. The treatment of the secondary stage of the disease is not commenced until the particular form that it assumes is evident. If the patient has an excellent constitution and a good appetite, it is not considered necessary to give him either iodine or mercury, for it is claimed that robust health with a good appetite, and strict attention to personal cleanliness stand next to mercury and iodine as antidotes to the poison of syphilis. During the two to three years that the secondary stage is supposed to last the patient has two or more relapses, and as a relapse is always more difficult to get rid of, it is recommended when the first secondary symptoms are slight not to give either iodine or mercury, but to reserve these agents for a later period. If iodine is used for the first crop of secondaries, it will be found to have much less effect on the second or third crops, than if it had not been used during the first. This statement applies also to mercury. It is further maintained that this is true not only of the different crops of the second stage, but also of those of the third stage of the disease. If iodine is used for the treatment of the second stage of syphilis, it will be found to have much less effect over the tertiary symptoms than mercury, and if mercury is used for the secondary stage it will be found to have a less influence over the third stage than iodine.

As a rule the practice here is to give iodine during the secondary stage, when the symptoms are of a pronounced character. If they do not readily yield, or if the iodine is ill borne then mercury is given. Mercury is also given if the case is a particularly severe one. Iodine is considered to be as useful during the secondary as it is during the tertiary stage of the disease.

In either stage it is not like mercury a direct antidote of the poison, but acts indirectly by its favoring tissue changes, and increasing the resisting powers of the patient. Whatever preparation of iodine or mercury is used in the treatment of syphilis, only harm results if digestion is materially interfered with. This is a point of great practical importance, and one too often neglected. For the severer and more rebellious forms of the secondary stage, mercury must be used.

In scrofulous and tuberculous subjects it is very often found that neither mercury nor iodine have the wished for effect, until the patient has taken for some time iron or cod liver oil.

The rule that is generally followed here as to the choice between the iodides and mercury is to give the former in the moist and the latter in the dry secondaries. The division of the secondaries into dry and moist is considered to be one of great practical importance. It will always be found that the dry eruptions occur in the weak and badly nourished, while the moist occur in the strong and well nourished.

There are three methods in use in the administration of mercury: 1. Inunction. 2. Internal. 3. Hypodermically. The method by fumigation has been discarded.

Inunction is the method most commonly employed. It is certainly for the great majority of cases the most trustworthy. By no other method can we get the system so quickly under the influence of this drug. In gummata of the nasal septum, roof of the mouth, etc., where hours are precious in order to save the hard tissues from destruction, it should always be used. In syphilitic lesions of the nervous system (be the change from a circumscribed gumma, or from the blocking of an artery by cellular infiltration), where irretrievable damage

will happen in a very short time, the introduction of mercury into the system by inunction should always be a part of the treatment. Whatever else is given, mercury should never be neglected in these cases. To treat these cases with iodide of potassium alone as is often done is considered by Neumann to be only half treatment. After the third inunction mercury can generally be found in the urine, and after the fifth, there are distinct signs of stomatitis.

The following is the process followed in the inunction cure: The preparation generally used being a finely divided ointment made up of one part of mercury and two of lard. After a warm bath the patient commences the first day of treatment by rubbing the ointment into the external and internal surfaces of the legs. The surface over the tibia is avoided on account of the ease with which eczema is produced. On the second day, the inner surfaces of the thighs; on the third, the sides of the trunk; on the fourth the inner sides of the arms and forearms are rubbed by the patient; and finally, on the fifth day, the rubbing is done by an attendant over the back, on each side of the spine and about a hand's breadth from it.

Only a small portion of ointment is taken at a time—a piece not larger than a pea—and this rubbed slowly until the parts are dry, the process being continued until the desired quantity has been used. It always requires half an hour, and often an hour before one drachm can be rubbed in. On the sixth day, the patient gets a warm bath, and on the seventh day he commences the rubbing again, and follows the same order as before. This process is continued until the symptoms disappear. In the secondary stage it requires from thirty to fifty rubbings for this end to be obtained. It is extremely rare to find a case in the second stage that resists sixty rubbings. A very important point in carrying out this form of treatment is to insist upon the patient keeping his mouth and gums clean. Unless this is done a severe stomatitis is apt to set in which necessitates the discontinuance of the treatment. The remedy above all others that is best for the prevention of a too severe or a too early stomatitis is tar—the ordinary pix liquida. When stomatitis

has set in, it is best treated by tar also. It is surprising how soon it affects a cure in even very severe cases of mercurial sore mouth.

A slight stomatitis is produced by mercurial inunction after the fifth rubbing. If a patient after ten or twelve rubbings has not slight salivation, with swelling of his gums and a coppery taste in his mouth, it is a certain proof that he has rubbed badly.

The rubbing of mercurial ointment into the skin is apt to induce eczema in some people, this and the fact that it takes up some time are the only objections to this method. The latter objections, however, can be got rid of by using a preparation made by mixing one part of mercury with two of green soap. The mercury should be so finely divided that it cannot be seen with a loupe. The addition of a very small quantity of glycerine helps to divide the mercury. From one to one and a half drachms of this preparation can be rubbed into the skin in ten minutes. It is as liable to cause eczema as the ordinary ointment.

3rd. *The Internal Administration of Mercury.*—No matter what preparation is used, it is apt to give rise to catarrh of the stomach. It is also a very inexact method, for we can never be sure what amount of the drug is absorbed. Calomel is used for children and weak persons. It is especially good in hereditary syphilis. It is usually given in the form of powders with sugar, and in doses for adults of from one-fourth to three-fourths of a grain three times daily. Corrosive sublimate is only used for adults. It is given either in pill form or solution in the usual doses.

4th. *Subcutaneous Injection.*—This method of introducing mercury into the system is also extensively used in Neumann's wards. It is only used however in the treatment of the secondary stage, and the slight forms of the tertiary stage. For the severer forms of the latter stage its action is too slow.

The preparation for hypodermic use is the formiamid. Its injection under the skin causes no pain. This preparation is made in Berlin, and was first recommended only a few months

ago by Liebreich of that City. It has been used in Neumann's klinik in over two hundred cases, and always with good results, and only once was its injection followed by the formation of an abscess. In every one hundred grains there is one grain of mercury.

Until recently, corrosive sublimate was extensively used for hypodermic injection. It answers very well, but it is apt to cause a burning sensation which lasts for two or three hours. It is very rare that its use in this way is followed by abscesses. The peptonate and albuminate of mercury first recommended by Bamberger are used also. Both preparations are free from irritating qualities, but as they require to be daily freshly prepared they are not likely to come into general use.

In using any preparation of mercury hypodermically it is very important, first, that the syringe used should be antiseptic ; and, secondly, that the injection should be made into the subcutaneous cellular tissue, and not into the skin or muscles. The skin should be avoided on account of the danger of producing abscesses, and the muscles from the fact that they contain few absorbents. The back, three or four inches distant from the spine is the best situation for the injections.

In using mercury in any form it should be remembered that it is very slowly excreted. Considerable quantities can be found in the urine three weeks after any has been used. After a month's inunction treatment, it can be still detected eight months afterwards in the urine. Prof. Ludwig has several times found mercury in the urine of some of Sigmund's cases, three, four and five years after they had stopped using it.

There are three different preparations of iodine used here in the treatment of syphilis. They are the iodide of sodium, which contains sixty per cent., the iodide of potassium which contains eighty per cent., and iodoform which contains ninety-three or ninety-four per cent. of iodine. The iodide of sodium is better for children and weak persons. Iodoform is only used hypodermically, one part of iodoform dissolved in six parts of ether being the formula used. It does not give rise to any local reaction, and its injection is not painful. For mild cases twenty

injections will be sufficient, but for the severer forms fifty are often required. Iodoform is considered to be as useful as the iodide of potassium in either the secondary or tertiary stages of the disease.

THE STUART PERIOD FROM A MEDICAL STANDPOINT.

By R. L. MACDONNELL, B.A., M.D.

[*A Paper read before the Athenæum Club, Nov.* 28, 1882.]

The physicians of the 17th century played an important part in medical history. Anatomy and physiology began with Harvey, rational therapeutics with Sydenham. Astronomy was beginning to be developed from astrology ; chemistry from alchemy. It was pre-eminently the age of the anatomists and physiologists. The names of many parts of our bodies bear testimony to the extent to which these studies were carried by the men of that period. Thus, the circle of Willis, the foramen of Vesalius, the tubercle of Lower, the Malpighian tufts, all serve to keep these great names fresh in our memory.

Upon examining the records of the illnesses of the great persons of the past, one finds grand opportunity for the play of the imagination.* What effect would modern scientific treatment have had upon their diseases, and what result would their cure have brought about? How much longer would they have lived, and what effect would the prolongation of their lives have had upon subsequent events. Had Henry VIII. had a 19th century physician, the disease from which he suffered would not have descended to his unborn children. Catherine of Aragon might have been the mother of many Tudors, the Stuarts would never have been heard of, the Reformation postponed, and Henry himself would have been talked of to-day as a model father and husband.

Queen Mary's cruel disposition, if not the actual result, was certainly intensified by the disappointment which followed her

* A writer in the *Athenæum* (Sternberg), in 1856, thus puts it: "History has been done philosophically, statistically, comically, but never physically or psychologically. A medical Niebuhr, with a moderate share of impudence, might resolve every page of record into a simple diagnosis."

fruitless marriage. Sir Henry Halford thinks that a course of aloes and iron might have changed the course of events in England and Europe.*

A few ounces of quinine judiciously administered, and Oliver Cromwell might have lived to three-score and ten.

The principal physicians at the Court of James the First were Sir Simon Baskerville, Sir Theodore de Mayerne, Dr. Craig and Sir William Paddye. The great Harvey was appointed extraordinary physician to the king by reversion, but his services were not required at the court until the accession of Charles I. Of Sir Simon Baskerville little is known, beyond that he was a very fashionable doctor, and in high practice amongst the cavaliers. He was the physician of Archbishop Laud. Dr. Craig was an outspoken Scotchman, and we shall presently see how he got himself into trouble with the meddlesome old ladies who crowded about King James' deathbed. He was the son of a famous Scotch lawyer, was elected a Fellow of the Royal College of Physicians of London in 1604, and in the following year was admitted to the degree of Doctor of Medicine at Oxford. Dr. Craig was a very learned man. According to Wood (*Athenæ. Oxonienses*, Vol. I., p. 469), he gave to Napier of Murcheston the first hint which led to his great discovery of logarithms. "He told him," says Wood, "among other discourses, of a new invention in Denmark by Logomontanus, as, 'tis said, to save the tedious multiplication and division in astronomical calculations. Napier, being solicitous to know further of him concerning this matter, he could give no other account of it than that it was by proportional numbers, which hint Napier taking, he desired him at his return to call upon him again. Craig, after some weeks had passed, did so, and Napier then showed him a rude draft that he called 'Canon Mirabilis Logarithmorum,' which, with some alterations, was printed in 1614."

* Mary was bled frequently. "It appears, in Sir Frederick Madden's introductory memoir to the privy purse of Queen Mary, that she was bled very frequently, and that fees were paid again and again, and again, to the surgeon who bled her; till at last she grew so pale, as to convey, even to unprofessional eyes, a conviction that she labored under an internal organic disease."

Sir Theodore de Mayerne, who had the honor of being physician to four kings—Henry IV. of France, James I. and the two Charles of England—played a remarkable part in the medical history of the period. He was born at Geneva in 1573, and was the son of a Swiss Protestant. He was educated at Heidelberg and Montpelier. He soon became a lecturer on anatomy in Paris, and, at the same time, paid some attention to the study of chemistry. Dr. Mayerne was the first to use chemical remedies in his practice, and introduced the use of calomel to the profession. His success was so great that he was appointed physician to Henry IV. of France, and in 1606 was induced by Anne of Denmark to accompany her to London, where his remarkable talents soon gained his appointment to the post of chief physician in ordinary to His Majesty. Mayerne's success in practice and at court procured him many enemies. His foreign manners and style of speech exposed him to ridicule. Shakspere, in the character of Dr. Caius in the "Merry Wives of Windsor," is supposed to be making fun of the French doctor. If 1606 be the date of Mayerne's arrival in England, and 1596* the date of the play, then Mayerne can scarcely be the person aimed at; nor do I see any allusion to Mayerne's career in the play. Mayerne's father was a literary man of some note in his day, and wrote a history of Spain. Nevertheless, Sir Theodore's foreign origin gave rise to many absurd reports regarding his career previously to his landing in England. Gideon Harvey, "their Majesties' Physician of the Tower and Fellow of the Colledge of Physicians of the Hague," in 1689, mentions Mayerne in terms the most contemptuous. Gideon relates the case of a patient who goes to consult Sir Theodore Mayerne, who is then living in retirement at Chelsea, a long way out of town in those days. Mayerne, he says, gave advice to this patient "without consulting the will and pleasure of God Almighty, an arrogance unheard of, and savoring more of the atheist (as too many of 'em are) than a pious physician." He accuses him, too, of prescribing a nostrum—"the great empirical medicine, from which his father, Turquetus (usually by the French nicknamed the Turk), had got great reputation by selling it publickly

* Chalmers.

on the stage, whom Sir Theodore, in his younger days, had attended in that employ." In a letter from John Chamberlen to Sir Dudley Carleton, Aug. 11th, 1612, Mayerne's appointment is mentioned as having given dissatisfaction. "Much envy was caused by Turquet's (Mayerne's) preferment, who hath £400 pension of the king, £400 of the queen, with a house provided him, and many other commodities which he reckons at £1400 a year."

Sir Theodore, for the benefit of posterity, left many published volumes on subjects connected with the prevalent dispute about chemical remedies. The most valuable of his legacies consists of records of the cases of the notable people who formed his *clientéle*. These entries in his diary are very interesting, in fact, as one of his biographers observes, might well be entitled, for the period they embrace, "The Medical Annals of the Court of England." There were 19 manuscript volumes, folio and quarto, exclusive of a volume relating entirely to the health and habits of James I. The later volumes, entitled "Ephemerides Anglicæ," relate to the disorders and cures of persons of quality of both sexes. The whole is written in very bad Latin, with a sprinkling of French words. Where the diseases are those of a nature not creditable to the moral antecedents of the sufferer, a *nom de guerre* is used. Thus Buckingham, who was constantly in trouble, is called "Palamedes," and Prince Charles is "Monsieur de la Fleur de Lys." Rochester ("Le Cardinal Joyense") is continually being treated for "debilitas," although he is described as being "admodum salax." Here is a portrait of the Marchioness of Buckingham:—

"Januarii 24, 1622. Madame la Marquise de Buckingham. Annum ætatis agit xix. Habitus gracilis, corpus *μονογραμμον*. Temperamentum ex sanguineo biliosum. Faciei color floridus. Mores compositi. Summa cum gravitate modestia. Vitium conformationis in spina dorsi. Gravida est et credit longissimum partus terminum fore diem Annunciationis B.V.M. 25 Martii."

Then again:

"Preparationes missæ ad Ser Walter Ralegh; parandæ pro Ser Roger Aston."

"My lord Duc de Lenox, Diarrhœa a liberiori victu."

"Madame de Hadingthon, Affectus hystericus et melancholicus."

The manuscripts which are now in the Sloane collection contain the histories of all his other patients, amongst whom were Lord Monteagle, Lord Arundel, Lord Clanricarde, Casaubon, Sir Henry Wotton, Arthur Brett, Oliver Cromwell, and very many others. His case-books show, too, that Mayerne's attentions benefitted alike man and beast. Nor was he above prescribing perfumes and cosmetics. In 1611, for Lord Hay, he compounded "odoramenta et quæ ad ornatum," "Pasta ad manus dealbandas et emmoliendas." In 1617 the queen's black horse was seized with convulsions, and in 1636 the king's dogs were indisposed. Sir Theodore takes up his pen and carefully notes the line of treatment he thought fit to adopt: "Pro equo nigro Reginæ epileptico." The history is complete, beginning with "equus est novem annorum," and ending "curatus fuit."*

Mayerne was the compiler of the first Pharmacopœia which was published by the Royal College of Physicians in 1618.

As a chemist, Mayerne had no equal. The results of his researches in his line were of benefit to art as well as to medicine. To both Van Dyck and Rubens he gave valuable information concerning the composition of paints and the use of the mineral colors. In the last chapter of Eastlake's "Materials for a History of Oil Painting" are numerous details as to colors and oils, brought out in a conversation between Van Dyck and Mayerne, and recorded by the latter. He gave valuable assistance to Petitot, his compatriot and fellow exile, who afterwards became the famous enamal painter.†

Mayerne attended Henry, Prince of Wales, in his fatal illness. From Sir Charles Cornwallis'‡ "Life of the Prince Henry," the following particulars concerning this remarkable fever are taken. The physician of the present day recognizes at once the now familiar typhoid fever, a disease in those days undescribed. From the very first it was said the Prince was poisoned. Rochester,

* These extracts from the Mayerne manuscripts are taken from Wadd's "Mems, Maxims and Memoirs," London, 1828, and from an article by Sternberg in *Athenæum*, 1856.

† M. F. Sweester's "Life of Van Dyck," Boston, 1878.

‡ To be found in the Somers Collection of Tracts, Vol. VI, p. 413.

afterwards Earl of Somerset, was at once suspected. People even hinted that the king was privy to the plot. Rochester was under suspicion because it was well known that he and the Prince were rivals for the favors of Lady Essex.* Typhoid fever was then a disease either new or not described. Many other cases of it occurred at about this time. In a newsletter written shortly after the death of the Prince, the fever is spoken of as being either a "bastard tertian or the ordinary disease of the time, wherewith all parts of the country have been much visited." Another writer of the period states that it was new to the physicians, and was thought by them to have been brought from Hungary. A short time afterwards, the Countess of Oxford died of the "new disease."*

The prodromata of the prince's fever made their appearance early in October, 1612. "Continuall headache, lazinesse and indisposition increasing, which, notwithstanding because of the time, he strove mightily to conceal." By the seventh day the disease was fully declared, and by the ninth began to assume a dangerous type. At this period the prince's body physician summoned Mayerne. The great error of bleeding the prince was committed. Mayerne was led to this step by the fact that bleeding of the nose had set in on the 20th day. This is a symptom of typhoid fever which we recognize to-day as an indication of extreme debility. Butler of Cambridge was called in at this stage. This extraordinary individual, of whom many amusing stories are told, acknowledged that the diagnosis puzzled him, and gave little hopes of recovery. Cornwallis speaks of Butler as "the famous physitian of Cambridge, a marvellous great scholler, and of long practise and singular judgment, but withal very humorous." John Chamberlen writes of him "that though he was otherwise but a drunken sot, yet he had a very shrewd judgment"; and in connection with his attendance upon the Marquis of Salisbury, "Butler of Cambridge" he says, "gave hard censure, but, thanks be to God, he proves a false prophet, and what for that and his other rude behavior was quite discarded." On the 22nd day of the fever there was delirium.

* Birch, "The Court and Times of James I."

The head was shaved and cupping glasses were applied to the back of the neck. On the following day, "a cocke was cloven by the back and applied to the soles of his feet, but in vaine." After the 23rd day all hope was abandoned. The king requested Mayerne to assume complete charge, but the responsibility was declined. The prince died on the 28th day.

My reasons for supposing this disease to have been typhoid fever are as follows:—1. The mal-hygiene of the period. 2. The time of year, the autumn. 3. The insidious nature. 4. The duration of the disease. 5. Headache, followed by delirium. 6. Bleeding from the nose. 7. The presence of diarrhœa.

According to the custom of the period, one not altogether extinct in these enlightened days, nostrums were sent to the prince with the compliments and recommendations of many distinguished persons. Sir Walter Raleigh, who lost a good friend in the young prince, sent from the Tower his famous fever cordial. The queen specially recommended it, since she herself had, in a previous illness, derived much benefit from it. No sooner was Prince Henry dead than the usual cry of "poison!" was raised. Strangely enough, it was rendered louder by an indiscreet word or two in the letter which Sir Walter Raleigh sent with his cordial. His words were, "it would certainly cure Henry of a fever, except in case of poison." So great was the public faith in this cordial, that the very fact of the prince's dying at all was looked upon as proof positive that he must have been the victim of a murderous conspiracy.

Sir Walter Raleigh was very fond of amateur therapeutics. In a letter from John Chamberlen to Sir Dudley Carleton in 1612, there occurs this passage: "The widow Countess of Rutland died about ten days since. Sir Walter Raleigh was slandered to have given her certain pills that despatched her."*

Mayerne was generally blamed for maltreatment of the Prince Henry. Butler is reported to have said that the patient should have been blooded earlier and should never have been purged. The French physicians set forth hard censure; "they call him *temulentum*, *indoctum*, *temerarium*, *et indignum*, with whom no

* "Court and Times of James I." Birch. London, 1848.

learned physician should confer or communicate." A history of the case in French and in Latin was written by Mayerne, who procured from the king a certificate expressing the most perfect satisfaction with his conduct, and two others from the lords of the council and the officers and gentlemen of the prince to the same purpose. In Mayerne's case-book, the entries relating to the death of Prince Henry have all been torn out, most probably by Mayerne himself. Curiously enough, in connection with this fever of the Prince of Wales, I find in a recent publication of the St. Bartholomew's Hospital Reports an article by Dr. Norman Moore, entitled "An Historical Case of Typhoid Fever." The author considers that to Mayerne is due the credit of having been the exact describer of the earliest case of typhoid fever on record in England. Dr. Moore criticises the history of the case as written by Mayerne, and reduces it to the concise shape of a modern case report. The diagnosis, in the light of subsequent experience, is beyond a doubt. The autopsy is confirmatory of this view. The work from which Dr. Moore's history is taken is entitled "Theo. Turquet Mayernii Opera Medica." Ed. J. Browne, London, 1701. I do not think there is a copy of this book in America.

James I., at the age of 59, after having been subject to attacks of ague and gout at different periods of his life, met his fatal illness on the 12th March, 1625. On that day Mr. Chamberlen, in one of his letters, states that "the king was overtaken on Sunday with a tertian ague," and on the 16th Mr. Secretary Conway, in a letter to the Earl of Carlisle, speaks of "the sharp and smart accesses of his Majesty's fever, though a pure intermitting tertian, whereof this day early he had his seventh fit." Affairs went badly with the king. On the 12th night of the illness, the last sacrament was administered. He appears to have died insensible. There are several records of the examination of the king's body. The most rational one is that found in Nicholl's "Progresses of James I. Death resulted from a form of what is now called Bright's disease. One kidney was found to be much atrophied; two calculi were found in it. The heart was enlarged. Sir Simon D'Ewes records that "the greatness

of the king's heart argued him to be as very considerate, so extraordinary fearfull, which hindered him from attempting any great actions."

According to another account, the head was found so full of brains that they could not keep them from falling out, "a great mark of his infinite judgment," but his blood was "tainted with melancholy, and the corruption thereof the supposed cause of death." On the back of an engraving in the collection of Beckford of Fonthill, there is an account of this autopsy. Here it is stated that the spleen was enlarged. Death was really caused, then, by ague attacking a gouty man with damaged kidneys. A shilling's worth of quinine might have saved life.

Another very curious record of this illness was found written at the end of a Book of Common Prayer, in the library of St. John's College, Oxford. The author of it was Sir William Paddye, a physician of great name, one of the king's attendants. "Being sent for to Thibaulde butt two daies before the death of my soveraigne lord and master King James, I held it my christian dutie to prepare hym, telling hym that there was nothing left for me to doe (in ye afternoon before his death ye next day at noone) but to pray for his soule. Whereupon ye Archbishop and ye Lord Keeper Byshop of Lincolne demanded if his Majestie wold be pleased that they shold praye with hym, whereunto he cheerfullie accorded. And after short praier, these sentences were by ye Byshop of Lincolne distinctly read unto him, who, with eies (the messengers of his hert) lifted up into Heaven, att the end of every sentence, gave to us all thereby a goodlie assurance of those graces and civilie faith wherewith he apprehended the mercy of our Lord and onelie Saviour Christ Jesus, accordinglie as in his goodlie life he had publiquelie professed."

The attendants in this illness were Sir Theodore de Mayerne, Sir William Paddye, and Dr. Craig.

Again there was meddlesome interference with the medical men, which in this case was a cause of great trouble to all concerned. Everybody had an infallible remedy to offer to the king. The Buckingham party, including the duke's mother, anxious to meddle in everything about the court, brought suspicion upon

themselves by secretly applying a plaister to the king's wrists without the consent of the physicians. This was done injudiciously at the wrong time. It was put on before the paroxysm began. It should have been done just as it was declining, and then by the *post hoc* argument they might have claimed the honors. Unfortunately, the king got worse, and just at the time they had made up their minds to remove the noxious thing, the fit began to decline, so that the doctors were quick enough to claim that the improvement was due to its removal. The sons of Æsculapius then refused to continue the treatment. Promises of good conduct having been made, they saw his Majesty through his fifth, sixth and seventh fits. Again dissatisfied with the progress of the case, the Buckinghams applied their plaisters, but the patient grew worse, and it is a matter of history that the Royal Chirurgeon had to get out of his bed to remove it. Dr. Craig was particularly incensed at these proceedings, and, according to Dr. Fuller (Church History), "he uttered some plaine speeches, for which he was commanded out of court." The Duke of Buckingham secretly administered a julep, after which the king was said to have grown rapidly worse. This interference with the medical men cost Buckingham much trouble. Dr. Geo. Eglisham, one of the King's Scotch physicians, publicly charged him with having poisoned his master. In the impeachment of Buckingham, his accusers did not forget this affair. The 13th count of the impeachment (Howell's State Trials, Vol. II, page 1318) is entitled "His transcendant presumption in giving physic to the king," and it is therein set forth that "he did unduly cause and procure certain plaisters, and a certain drink or potion to be provided for the use of his said Majesty, without the direction or privity of his said Majesty's physicians, not prepared by any of his sworn apothecaries or surgeons . . . . did produce such ill effects that some of the sworn physicians did altogether disallow thereof, and utterly refused to meddle with his said Majesty until these plaisters were removed."

(To be continued.)

NOTES ON HARELIP.

By T. G. RODDICK, M.D.,

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(Abstract of a paper read before the Medico-Chirurgical Society of Montreal.)

Almost the only excuse I can offer for presenting so commonplace a subject before the members of the Society is, that I have had an opportunity of treating some twenty-five cases of this deformity in both hospital and private practice, and hence have been enabled to lay down for my guidance certain rules, which are not always clearly defined in books, but which may assist in guiding others whose opportunities have been fewer and less varied.

A word, in the first place, as to the etiology of harelip. Perhaps not more than twelve per cent of all the cases are really hereditary. I have noticed, moreover, in this connection, that the line of transmission is seldom direct, the rule being to skip one generation entirely. Thus a man with harelip will have a large family, none of whom inherit his deformity; but probably several grand-children will be afflicted. Now and then the line is still less direct, the impression coming from a distant branch of the family tree. As to the influence of maternal impressions in producing deformities of this kind, I think something may be said in its favor, although my belief in this direction is not nearly so strong as that entertained by many observers. One of the most striking illustrations of this impression as a cause of harelip came under my notice in connection with a case on which I operated about two months ago. The mother stated that during about the fourth month of pregnancy she was living in one of the villages on this island, and one day visited the house of a neighboring farmer. Here she was confronted by a grown girl having a very hideous harelip. The impression made was instantaneous and abiding, and the child was born with what had originally been a severe form of harelip, but a considerable amount of healing had taken place *in utero*, as shown by the scar present. Fergusson (Sir William) used to think that a very slight peculiarity in the mouth of either parent was often the cause of

harelip. The following rather ridiculous story was told me by the mother of one of my cases operated on some two years ago. She said that while she was carrying the child, at about the third month, her husband, without her consent, had his moustache shaved off, exposing a very bad set of teeth. She was very much annoyed at this, and could not help upbraiding him constantly. The child was born with a complete harelip, and the husband is blamed to this day for having shaved.

As to the occurrence of other malformations (not including cleft palate) in the same individual, I know of only one case where club foot was also present. I have, however, repeatedly seen congenital deformities in other members of the same family. I show you now the photograph of a girl of eighteen years, on whom I operated successfully for double harelip, and who had congenital alopœcia, the scalp being covered here and there only by a few downy hairs. In a case of harelip, which Dr. Alloway requested me to see with him a short time ago, there was marked cyanosis, due doubtless to non-closure of the foramen ovale. Owing to this, and the fact that an anæsthetic could not be given with safety, the operation was deferred and fortunately, too, as she died soon after.

Now as to the operative measures for the correction of this deformity: First, at what age should the operation be undertaken? This is often a very difficult question to answer; but will usually depend on the condition of the child, and the amount of deformity. There are two very serious objections to an early operation, namely, the very friable and lacerable condition of the tissues which allow the sutures to cut out too rapidly, and again the fact that young infants bear the loss of blood very badly. Then an equally grave mistake could be made in deferring the operation too long, or until dentition sets in. I think the following rules may be safely followed in these cases: Where cleft palate complicates the harelip, and the child feeds with difficulty, the operation may be performed between the fourth and sixth week; where the harelip is uncomplicated, the operation will do best if deferred to the third month. I am aware that the operation has been often per-

formed at a very early date, owing to the urgent solicitation of friends, but I think no surgeon should allow anything of the kind to warp his better judgment. The responsibility really rests with himself, and in the event of a failure the parents will very seldom be found willing to share it.

I always give an anæsthetic, and prefer ether to chloroform even in the infant of a month old. It may be a little more troublesome, but can be given as fearlessly as in the adult. I am not among those who believe that chloroform can be given with impunity to children. My experience may be singular, but I have witnessed alarming symptoms more frequently in them than in grown persons, and I believe the chief explanation of the comparatively infrequent fatal results in children lies in the fact that they are so much more readily handled than adults during the efforts to resuscitate.

I notice that many surgeons prefer scissors to the knife in paring the edges of the harelip fissure. I used them in one case only, but have never ceased to regret it. They bruise the tissues, and in that way interfere with primary union. Besides it is next to impossible for one to save the parings when scissors are used. They may, however, be employed with advantage in separating the lip from the underlying gum. A narrow bladed knife—an ordinary tenotomy knife in fact—will be found to answer the purpose best. When one is not provided with a skilled assistant, hemorrhage may be readily controlled by applying on either side of the fissure a pair of dressing or Pean's forceps, the blades being compressed by applying an elastic band to the handles.

As to the sutures employed, I use in all cases the hare-lip pin and cat gut, excepting in the very simplest form where wire may be substituted for the pin. In order to support the pin and at the same time exercise a sort of splint-pressure on the sides of the fissure, I have been in the habit of using flat leaden discs, perforated in the centre, and of the size and shape I show you, taking the precaution to pad them on the lip side with lint or rubber tissue. Prepared in this way it will be found that the needles will not cut the tissues of the lip, and can, if neces-

sary, be left *in situ* a much longer time than without the discs. Thus in persons over a year old I constantly leave the pins in till the third or even the fourth day.

In cases of harelip complicated with cleft palate, not only is there a wide gap in many cases between the two portions of the jaw, but the longer portion, or that having attached to it the intermaxillary process, will be found to overlap the other often to the extent of three-quarters of an inch. Now while an operation for the closure of the entire cleft is not practicable in a child of only a few weeks old, much may be done to lessen the gap, and place the parts in a better position for a subsequent staphyloraphy. Thus I invariably break down the projecting portion to the level of the other, either by the pressure of my thumb, or, when the bone is too firm, by deliberately fracturing the jaw with a chisel opposite about the canine tooth of that side. The edges of the two portions are then pared and held together by means of a strong silver wire passed through at a distance of at least half an inch from either edge. This wire is left in for about a month, when it will be found that the line of the gum is perfect, and the cleft through the hard palate has been lessened to a degree often astonishing. More than that, this narrowing process will continue often for many months, so that by the second year the fissure will sometimes be found to have almost closed. I show you here a pair of forceps, having broad smooth blades, with which the projecting portion of jaw can often be broken down when the thumb fails.

Next as to the treatment of double harelip and the management of the median tubercle or intermaxillary bone. I have had two cases only of this kind. The soft parts have to be treated in very much the same way as in the single variety, but care must be taken not to draw the skin covering the tubercle too far down towards the edge of the lip, otherwise the point of the nose will become flattened, and an unsightly appearance be given to the person. This occurred in my first case, and I was obliged to free the nose by a subsequent operation. This intermediate portion should be utilized simply to complete the columna, the point only entering into the formation of the

lip. As to the management of the intermaxillary bone, this may be dealt with in a variety of ways. The most expeditious method, of course, and that advocated by many surgeons, is to remove it altogether. This, however, causes the lip to fall in, and gives the patient a peculiar expression. The process should then if possible be preserved; this can be done by simply breaking it away from the vomer and pushing it back into the gap between the two lateral portions of the jaw. Should the space not be sufficiently large to receive it, the edges of the cleft may be pared away, and the process held *in situ* by means of a wire suture.

In the after treatment of harelip I have never found it necessary to employ Hainsby's truss or any apparatus of that kind. The application of straps of Mead's rubber plaster, made broad over the cheeks, and approximated across the lip by lacing with thread, will be found necessary in a few cases only. Great care should be taken, however, not to make the plaster crossing the lip too wide, as I have known it to cause the upper portion of the wound to gape by pressing on the nostril above.

A word in conclusion on the method of feeding the child. The majority of surgeons recommend that the child be put at once to the breast. This may answer very well, and doubtless is the best practice when the nipple of the mother is small, prominent, and readily grasped by the child; but on the other hand I have known serious mischief to follow persistent endeavors on the part of the mother to push a large nipple into the tender and contracted mouth of the child after the operation for harelip. Hence in all cases it is better, safer perhaps, to feed the child with the spoon, at least for the first forty-eight hours after the operation.

CASE OF CONGENITAL DEFORMITY OF THE HANDS.

By JOSEPH WILLIAMS, M.D., Boston, Mass.

A recent obstetric case has furnished me with an example of a deformity which seems worthy of mention. There is nothing to note in regard to a supposed cause in the personal or family

histories of the parents; the pregnancy was normal and the child perfectly developed, with the exception of the hands.

In each hand there are only three metacarpal bones, the first and the fifth being wanting. The second, third and fourth digits are normal. The little finger in each hand has its articulation with the outer side of the head of the fourth metacarpal, and is set so closely to the adjoining phalanx of the fourth digit that there is probably an articular facet on the latter. As if to remedy this deformity as much as possible each little finger curves so as to form nearly a semi-circle, the extreme end of which touches the ulnar side of the fourth digit. The wrists seem unusually long and flexible; but whether there is any increase in the number of the carpal bones could not be satisfactorily made out.

The most visible deformity, however, is in connection with the thumbs. On the left hand there is no trace of a thumb; there is no cicatrix or irregularity on the radial side of that hand. On the right there was a thumb whose shape is best compared to that of the human stomach, the larger end being attached to the hand by a very narrow pedicle, while the more pointed extremity carries a diminutive nail. The mass measures 22 m.m. in length and 10 m.m. in greatest diameter; the pedicle is 5 m.m. long and of a uniform diameter of 2 m.m., and is so flexible that the thumb rolls about with the least movement. At the wish of the parents I removed this thumb. The pedicle contained blood-vessels but no bone or cartilage; the thumb possessed its two phalanges, the proximal one being rudimentary.

QUARTERLY RETROSPECT OF OBSTETRICS AND GYNÆCOLOGY.

Prepared by WM. GARDNER, M.D.,

Professor of Gynecology, McGill University; Attending Physician to the University Dispensary for Diseases of Women; Physician to the Out-Patient Department, Montreal General Hospital.

Necrotic Breaking-down of a Uterine Myoma during Pregnancy, by Dr. Krukenberg, assistant physician to the Gynæcological Clinic at Bonn. This is the title of a paper in the last

number, (Bd. XXI, Hft. 1, *Arch. f. Gyn.* 1883.) The author begins by stating that necrosis of a uterine myoma during the puerperium is not rare. During pregnancy at the most, œdematous infiltration of the tumor occurs. Most of the cases of gangrene of fibroids have occurred shortly after labor. Such an occurrence at this time is not to be wondered at. The copious supply of blood during pregnancy leads to rapid growth, and after its termination conduces to rapid regressive changes. The author reports the following case. He has been able to find only one other on record, Cappie's, published in the *Obstet. Journal of Great Britain*, 1874; Vol II., p. 303. The following is a brief account of the case reported by Krukenberg: The patient, aged 43, had always menstruated regularly and painlessly, and had been sterile during the two years that she had been married. The menses last appeared in the beginning of March. She remained in fair health till June 10th, when immediately after defecation without difficulty, she was seized with a severe vigor lasting five minutes, and accompanied with most violent pain in the hypogastrium. She could with great difficulty be got to her room. The physician in charge treated her for inflammation of the bowels; the pain subsided after two days, but she was obliged to keep her bed till the end of June. No vomiting, fainting or giddiness. The circumference of the abdomen increased. At the end of June patient was much better, but still had pain in the right iliac region. She was then admitted to the Clinic. Abdomen was enlarged; palpation painless, percussion showed absence of ascites; in the lower part of the abdomen were two tumors, that on the right was hard, that on the left firm and elastic. They were separated by a furrow, both were smooth. On auscultation, uterine souffle was heard in the right hypogastrium. Fœtal heart sounds inaudible. Dr. Veit, chief of the Clinic, could not arrive at a positive diagnosis; probably the patient was in the fifth or sixth months of pregnancy. Extra-uterine pregnancy seemed excluded. Probably the tumor on the left side was the gravid uterus, and that on the right a myoma. It was too firm for an ovarian tumor, and the line of separation between it and the uterus was not distinct enough.

About the first of August the left-sided tumor or enlargement had increased; the dividing line or furrow had become very indistinct; fœtal movements could be felt, and fœtal heart sounds were now audible. Morning temperature normal; in the evening, high fever, 39.9 Cent., but there was little regularity about the temperature; other organs healthy. These facts suggested suppuration somewhere. An irregular but increasing temperature continued. On the 11th August a severe rigor. Conditions otherwise unchanged. Opening the pus cavity seemed the only chance of saving life. The propriety of this course seemed assured by the history of an attack of peritonitis, whereby it was hoped that adhesion of the parietal peritoneum to the visceral layer had occurred. Next day, Aug. 12th, Prof. Veit with antiseptic precautions made an exploratory incision, but was completely disappointed in his expectations; there were no adhesions to obliterate the peritoneal cavity, only clear fluid escaped; no separation of the tumor or furrow could now be seen; the tumor mass felt much more like the gravid uterus than anything else, but harder on the right side than the left; the wound was closed. Eleven hours later labor set in, and at the end of five hours the fœtus enclosed in its membranes was expelled. The membranes healthy, the liquor amnii slightly turbid; fœtus recently dead, not macerated; to the right and above the uterus could be felt a hard tumor of the size of the fist; no abnormal escape of blood or pus; during the following day the belly became tender and tympanitic; occasional vomiting, delirium, herpes labialis, left sided parotitis; lochia fœtid, scanty, containing no pus; general condition was of typhoid character. Death occurred on the 18th Aug., six days after the exploratory incision. At the autopsy, purulent depots in the parotid gland and kidney; general peritonitis; ureters dilated to the size of the little finger. From the pelvis rose a tumor of the size of a child's head; from this two smaller myomata projected. On removing the parts from the pelvis, in the left side of the uterus, there lay an interstitial myoma about eight centimetres in diameter; its capsule averaged one centimetre in diameter; to the right and behind, it was very

much thinned, and at one spot completely absent. By this opening the capsule communicated with a collection of soft, broken down tissue and pus, part of the tumor was also softened.

Gartner's Canals.—Dr. J. Kocks, privat-docent of Obstetrics and Gynæcology at the University of Bonn, in a paper in the 20th volume *Archiv f. Gyn.* (1882), draws attention to two follicles which open more or less close to the posterior margin of the orifice of the female urethra; their length varies from a half to two centimetres. Kocks believes that they are the homologues of the ejaculatory ducts of man, of which in the female they are the embryonic remains. Gartner discovered these in ruminants and swine, but hitherto their existence in other animals has not been announced. They are evidently the same as described by Dr. Skene of Brooklyn in a paper, "Anatomy and Pathology of two Important Glands of the Female Urethra," published in the *American Journal of Obstetrics* for April 1880. In this paper Dr. Skene very fully describes the structure and diseases of the gland; they are liable to inflammation, in most cases occurring as extension from vulvitis or vagnitis. Skene has pointed out that the follicles when inflamed give rise to annoying symptoms, and require special treatment; curative applications, as tincture of iodine or solutions of nitrate of silver, must be applied within the follicles by fine probes coated with cotton, or if this fail they must be slit up like a sinus or fistula. In the healthy condition of the parts the openings of the follicles are within the orifice of the urethra, but when inflamed they cause an eversion of the mucous membrane to such an extent as to make them visible.

Professor Böhm of the Rudolf-Stiftung Hospital, Vienna, in a more recent number (Bd. XXI., Hft. 1, of the *Arch. f. Gyn.* 1883) also points out the frequency of inflammation of these glands, and asserts that he has seen it in virgins, prostitutes and married women. From my own experience I can confirm the above statements with reference to the existence of diseases of, and necessity for special application of remedies to these follicles. Neither of the German observers give any credit to, or even mention Professor Skene's observations.

On the Diaphoretic Treatment of Puerperal Eclampsia, with Hot Baths.—Our readers will remember that in a previous report I embodied a *resumé* of the results obtained by this method of treatment at Prof. Gustav Braun's Clinic, Vienna. Dr. Carl Breus, his assistant—the writer of the previous article—again appears in the last number (Bd. XXI, Hft. 1 of the *Arch. f. Gyn.*, 1883) with a report of eleven other cases, treated in the same way; of these eleven only one died, the other ten recovered—as the author remarks excellent results in such a serious disease. It will be remembered that the procedure consists in placing the patient in a bath of a temperature of 38° C., and gradually raising it. After the bath the patient is wrapped in warm sheets and blankets to encourage perspiration. This method of treatment in no way interferes but rather favors the carrying out of other indications for treatment; such as choloroform inhalation, chloral hydrate enemata, etc. A sketch of the history of each case is appended. Of the eleven cases in four the eclampsia occurred in the beginning of labor; in two after long duration of the first stage; once during the expulsion of the child, and four times after labor. The fatal case was syphilitic; was brought late to the Clinic for treatment, and had had many convulsions. She was, moreover, also probably in a condition of septic poisoning when brought in, as death was not caused by the eclampsia but by pelvic phlegmon and peritonitis four days after delivery, when the evidences of kidney affection had become very much diminished. This series affords a better showing for the treatment than the first series of six cases, of which one died. To sum up, of seventeen cases two only died. One only of the deaths being due to convulsions, the other as just related to puerperal peritonitis. Experience of the treatment has shown that it in no wise exposes the patient to the danger of premature labor. In two cases in which convulsions came on before the end of the full period of gestation, and which were treated by the baths and other diaphoretic procedures, labor did not come on till the end of full time.

Further evidences of the fact here stated are afforded by the

results of preventive treatment of several cases of œdema and albuminuria in pregnant women at the Clinic. In one notable instance a primipara, æt. 26, with bloody, highly albuminous urine, was transferred in the 8th lunar month of her pregnancy from Bamberger's Clinic to the Obstetrical Clinic for treatment. She was so dropsical that she could scarcely turn in bed, and suffered from intense dyspnœa from œdema of the bronchial mucous membrane and hydrothorax, aided, of course, by the normally lessened descent of the diaphragm by the gravid uterus in advanced pregnancy. She was treated with hot baths and packing. For more than ten weeks she was thus treated—forty-five baths in all having been thus given. The first baths markedly relieved the dyspnœa, lessened the œdema, and markedly reduced the quantity of albumen and blood in the urine. When on one occasion the baths were suspended on account of diarrhœa, the distressing symptoms returned. The patient was delivered spontaneously of a living child. The only interference being bilateral episiotomy, or incision of the perineum, rendered necessary by the œdema of the vulva. She died, however, later of an attack of pleurisy in Bamberger's Clinic, to which she had been removed for further treatment of her nephritis.

Shall Carbolic Oil or Vaseline be allowed to retain our confidence as a reliable Disinfectant Lubricant in Obstetrical practice?—Fehling of Stuttgart discusses the question in a recent number of the *Cent. f. Gyn.* Mixtures of carbolic oil or vaseline have been used for several years, and are still much employed for such purposes. Koch's recent researches are pertinent to this question, and tend to destroy confidence in the parasiticide properties of carbolic acid. He found that anthrax bacillus and its spores could be kept in carbolic oil for more than three months and retain their vitality. He also found that these spores retained their vitality as long in carbolic oil as in olive oil. Bacteria, moreover, are found, and continue to develop, in catgut preserved in carbolic oil. The most important lessons to be derived from these facts is that the disinfectant power of carbolic oil upon the fingers must be very slight, insufficient, and therefore dan-

gerous to rely upon, if, as in the Prussian Handbook for Midwives, it is the only one recommended. An important advantage, however, from the use of carbolic oil for such purposes is that it protects the examining finger from the infection of poisons, such as cancer, syphilis, and fœtid endometritis. For several years since he has used carbolic oil, Fehling has experienced none of the irritant or poisonous effects of these poisons on his own hands. Previously he very often suffered in this way. Carbolic oil, then, must not be relied upon to the neglect of thorough disinfectant washing of the hands of the obstetrician with the 5 per cent. watery solution of the acid. Fehling recommends, in preference to carbolic oil, the paraffine ointment of the German Pharmacopœia, with an admixture of 4 per cent. of carbolic acid. An ointment has this advantage over oil, that it does not drop on and so stain the clothing.

Effects of Hystero-Trachelorrhaphy on Fertility and Parturition.—This operation has been shown to be of the utmost value in the treatment of so many of the diseases of women, and is so frequently performed that the question of its effects on fertility and parturition may now be put with a fair expectation of receiving a definite answer. Within the last few months the obstetrical journals have contained articles and reports of discussions at meetings of societies, bearing upon it. Dr. P. J. Murphy of Washington, surgeon in charge of Columbia Hospital for Women, has a paper on this subject in the *American Jour. of Obstetrics* for January, 1883. After a brief introduction, he gives a *resumé* of all the cases whose history he could find in the library of the Surgeon-General. He found only 11 cases of pregnancy there reported. He therefore, and, as I think, without sufficient warrant, concludes that (1) the repair of lacerations of the cervix is usually followed by sterility; (2) that the character of the labour is severe and protracted, and that, in a large proportion, laceration occurs a second time; (3) that in order to ascertain the benefit of surgical interference in such cases, an examination should be made several months after the operation to determine the condition of the cervical canal and, if conception has taken place, the condition of the cervix following delivery.

At the meeting of the Obstetrical Society of New York for October 3, '82, Dr. J. B. Hunter related the case of a woman on whom he had performed the operations for a severely lacerated cervix and for a completely lacerated perineum. The child was born at full time, and weighed seven pounds. Neither cervix nor perineum gave way, although he believed the perineum had a narrow escape. He mentioned the case because so many physicians feared a reproduction of the injury at delivery after operations. This was only one of several which he had seen in which no injury was done to the repaired laceration at subsequent labors.

Dr. Skene of Brooklyn, who was present, said that he had seen several cases of successful delivery without injury to the repaired cervix and perineum. In some others in which laceration took place, it was only slight or partial, and was not complete in any. He could readily understand why this should be so, for with the development of the uterus during pregnancy, the compensation of normal tissue would be so great and the scar tissue so insignificant that there could be no more reason why laceration should occur than in a case in which it had not happened before.

Dr. Hanks said that in one of the first cases he ever operated on for laceration of the cervix, the operation was done at the Woman's Hospital of New York. He delivered the patient 18 months afterwards without any injury to the cervix. Since then he had had several cases, without relaceration.

Dr. C. C. Lee had operated in a case of double cervical laceration so extensive that very little of the true cervical tissue remained after its repair. An excellent result was obtained. He was particularly interested in this case, the laceration was so extensive. The woman was young, and expected to bear more children. She became pregnant. His associate, Dr. Swasey, attended her in her confinement, but no laceration whatever occurred. Dr. Lee examined her very carefully himself, but found no traces of anything of the sort.

Dr. B. F. Baer of Philadelphia, at the meeting of the Obstetrical Society of that city, Feb. 1st, '83, read a paper on the

"Analysis of 27 Operations for the Restoration of the Lacerated Cervix Uteri, with special reference to the effect on Sterility and Labor." He admitted the force and truth of a statement made by Dr. Herman of the London Hospital during a discussion in the Obstetrical Society of London following the reading of a paper on "Trachelorrhaphy, or Emmet's Operation," by Dr. Playfair. Dr. Herman said: "The American literature on the subject consisted mostly of general statements. Few writers had published cases, and they were mostly complicated ones." Dr. Baer next referred to the conclusions of Dr. Murphy, embodied above, and admitted the truth of his conclusion that repair of lacerations of the cervix uteri is usually followed by sterility; but he believes that the truth is not properly expressed, and that Dr. Murphy ought to have said that in those cases in which sterility followed the operation, that condition also preceded the repair of the cervix in most of the cases, either as a result of the laceration or of its consequences on the uterus and its appendages; and that the operation did not cause the sterility, but failed to cure it. Of Dr. Baer's 27 cases, 6 were widows or had passed the menopause, and are therefore to be excluded. Of the remaining 21, 13 had been sterile 5 to 16 years previous to the operation, and probably must be classed as beyond the possibility of becoming pregnant. In the remaining 8 cases, pregnancy had occurred within 5 years, but abortion occurred in 5. These figures, as Dr. Baer well remarks, give abundant proof of the ill effects of the lesion and its results, subinvolution, chronic hypertrophy, cellulitis, öophoritis, etc., on fertility.

The statement that sterility usually follows as a result of the operation is not correct, if it be properly done; the os uteri not made too small, and the union obtained is primary, the minimum of cicatricial tissue remaining to interfere with the normal resiliency of the cervix. Other reasons for sterility in such cases adduced by Dr. Baer are the histological changes in the uterus and its appendages, due to frequently recurring abortion, and the fact that in the majority of cases trachelorrhaphy has been performed long after the receipt of the lesion, because the operation is new, and there were many old cases. The author appends

short reports of cases selected from the twenty-seven, illustrating the points he makes in his paper. In the discussion which followed, Drs. Albert Smith, Githens, Montgomery, Cleemann, Wharton Sinkler and others, each reported cases of pregnancy and labor at full term, in the great majority without laceration of the cervix, following Emmet's operation. Here then, is a mass of testimony opposed to the prevailing idea in the mind of the general profession, to the effect that the operation causes sterility, or that, if pregnancy occur, laceration of the cervix will be reproduced. The point is of considerable importance. There is no doubt that many women are deterred by the advice of their physicians from submitting to a necessary operation until some of the more important secondary consequences of the lesion; such as chronic congestion or inflammation of the uterus and its appendages have set in, when the case is often rendered incurable.

Secondary Puerperal Hemorrahge.—At the meeting on January 18th, 1883, of the New York Academy of Medicine, Dr. P. F. Mundé read a paper on this subject. He said that the majority of obstretrical authorities scarcely refer to the possibility of alarming uterine hemorrhage occurring as late as several weeks after confinement. He reported a case in point. The hemorrhage did not occur until sixteen days after confinement. The child had been hydrocephalic and was delivered with the cephalotribe; hemorrhage occurred, the placenta was adherent, and the anterior lip of the cervix torn. She was feverish, and the lochia were offensive, the secondary hemorrhage was arrested for a moment by the intra-uterine injection of hot water, but it returned. Dr. Mundé then cleared out a mass of clots from the dilated vagina and distended uterine cavity, washed out the uterus with hot carbolized water; then introduced a tubular speculum, and through this with a long cervical syringe injected half an ounce of pure tinct. iodine into the uterine cavity, which caused neither pain nor shock. The patient was excessively blanched and weakened, but contrary to all expectations she slowly recovered, and five weeks later was completely convalescent.

The causes of Secondary Puerperal Hemorrhage Dr. Mundé enumerated as follows:—Constitutional: hemophilia, mental emotion, functional diseases of the liver, incautious use of stimulants, sudden assumption of the erect position. Local: Irregular or inefficient contraction of the uterus, clots in the uterine cavity, portions of retained placenta or membranes, retro-flexion of the uterus, laceration of the vagina or vulva, laceration or erosion of the cervix, inflammatory ulceration of the cervix, malignant disease of the cervix, pelvic cellulitis, inversion of the uterus, premature sexual intercourse, loaded rectum. To these he added distended urinary bladder. Besides these, malarial poisoning was a well recognized cause of secondary puerperal hemorrhage. General febrile disturbances were also causes of secondary metrorrhagia. Another cause, so far as he had been able to learn, spoken of by Winckel only, was disease of the inner surface of the uterus, chiefly endometritis. Dr. Mundé believed that his case belonged to that.

Secondary Puerperal Hemorrhage may occur as late as four, five or six weeks after delivery. For treatment he recommended injection, or swabbing the uterine cavity with tinct. of iodine, and if necessary the use of the vaginal tampon.—*American Journal of Obstetrics, March* 1883.

Martin's Operation is for the removal of uterine fibroids. It consists in performing laparotomy, causing the uterus to protrude through the wound, incising its wall opposite to the tumor, shelling it out and removing it. The uterine wound is then sewed up with numerous closely set sutures, and the abdomen closed in the usual way. A case of this operation is published by Dr. Möricke in a recent number of the *Zeitschrift für Geburtshülfe und Gynäkologie.* It occurred to him while in temporary charge of Prof. Schröder's wards during an illness of the latter. The patient, aged 35, had suffered from pain and hemorrhage, and was very anæmic. The uterus was about the size of one four months pregnant. The cervix admitted the finger, and by it a broad-based tumor could be felt springing from the anterior wall of the cavity. Ergotin internally and curetting of the endometrium did no good. After the opera-

tion there was fever, and on the 10th day pelvic exudation could be felt. On the 48th day fœtid pus was discharged from the vagina. After this the fever abated, and on the 76th day after the operation the woman left her bed. The fever, however, again returned; the patient wasted and died 111 days after the operation. At the autopsy peritonitis with sero-fibrinous exudation; a collection of pus in each broad ligament; almost complete involution of the uterus, and a healthy endometrium. Dr. Möricke thinks Martin's operation is an ideal one, and strongly recommends it.

Total Extirpation of the Uterus through the Vagina for Cancer.—This operation continues to be frequently performed, especially in Germany. It seems to have almost entirely displaced Freund's abdominal operation. At last year's German Medical Congress of Physicians at Eisenach, Olshausen reported that he had performed total extirpation of the uterus twenty-three times. Of these, three were not completed; one on account of rectal, and two on account of vesical adhesions. One case had a vesico-vaginal fistula as a sequel, and another an intestino-vaginal fistula. Of the remaining twenty cases six died. In nineteen there was carcinoma of the cervix; in three sarcoma of the body of the uterus. In one case the operation was performed on account of myoma of the posterior wall of the cervix. Of the survivors of the operation, in three the disease reappeared, and of these two died. In the last ten he had employed the elastic ligature exclusively, with carbolic acid irrigation, drainage tube in Douglas' pouch, and iodoform gauze. At the same meeting Martin reported that he had made thirty-one operations, in five of which all the diseased tissue could not be removed; of the twenty-six others four died. His method was to commence by opening the posterior vaginal cul de sac, and then to ligate the tissues to be divided, thus avoiding loss of blood. He employs drainage. He admitted that as regards return of the disease the operation was not successful. Of all his cases only one remained a year and a half free from the disease. At the same meeting Keyelmann stated that he had never seen a case of permanent cure of carcinoma obtained by extir-

pation. He therefore thought it ought to be reserved for cases of adenoma. Olshausen, Veit, Rinecker and Martin were, however, opposed to this view, as they have all seen cases in which long continued or permanent relief has been maintained. The experience of Martin as just given scarcely warrants the assertion on his part.—*Centralb. f. Chir.*, Jan. 20, 1883.

Reviews and Notices of Books.

Medical and Surgical Aspects of In-Knee (Genu-Valgum): Its Relation to Rickets, its Prevention, and its Treatment with and without Surgical Operation.—By W. J. Little, M.D., F.R.C.P., assisted by G. Muirhead Little, M.R.C.S. Illustrated with upwards of 50 figures and diagrams. New York: D. Appleton & Co., 1882. Montreal: Dawson Bros.

This compact and neatly gotten up little work of one hundred and sixty pages, is especially deserving of notice from the fact that its Senior Editor, Dr. W. J. Little, is well known to be the pioneer of Orthopœdic Surgery in England. He himself was at one time a patient of the great Stromeyer, having suffered in early life from one of the varieties of talipes. The work is dedicated by the authors to Prof Gross, "the Father of Surgery in America," in grateful acknowledgment of the reception accorded them during a recent visit to the United States.

The intention of the book seems to be chiefly to disprove some of the ordinary conceptions regarding the pathology and treatment of genu-valgum. Thus many surgeons of eminence have long contended that *enlargement* of the internal condyle is pathognomonic of in-knee. Whereas Dr. Little maintains that the external condylar part of the femur, and the external articular portion of the tibia are damaged and shrunken in this deformity, thus giving rise to the characteristic appearance of knock-knee. Much space is taken up to prove the rachitic origin of in-knee, a fact which few surgeons will question; although a non-rachitic variety is recognized and fully described. While the latter usually requires mechanical treatment only,

the rachitic form has to be reached often mainly through the constitution.

The surgical treatment is divided by the author into two parts: that which consists in manipulations and application of suitable contrivances, and that which consists of more abrupt means, such as tenotomy, forcibly straightening under anæsthesia, and osteotomy. Dr. Little makes the remarkable statement that he has never met with a case of in-knee that did not recover by the help of instrumental means alone. He deprecates the practice of performing osteotomy at all in young children, and in the case of adolescents even he thinks that the operation is justifiable only where adequate skillful instrumentation has been tried in vain. He, however, gives due credit to Macewen and others for their brilliant successes, and admits frankly that the Listerian system of antiseptic surgery has divested osteotomy of many of its dangers, and made it a really brilliant operation.

The book is neatly printed, and the woodcuts are very creditably executed. It is evident that the authors have spared no pains in its preparation, and we can strongly recommend it to those of our readers who may be interested in orthopædic work.

Trichinæ; their Microscopy, Development, Death, and the Diagnosis and Treatment of Trichinosis.—By W. C. W. Glazier, M.D., Assistant-Surgeon Marine Hospital Service, U.S. Seventeen woodcuts; pp. 20. Illustrated Medical Journal Co., Detroit, Mich. Price, 25 cents.

This little pamphlet, closely printed, gives a very full and reliable account of the life history of the formidable flesh worm, and of the symptoms produced by it. The material has been judiciously selected from the best authors, chiefly German, and there is nothing to lead one to suppose that the author has had any experience either in the investigation of the disease or the parasite. We believe, however, that Dr. Glazier has made some important researches into the prevalence of Trichinæ in American pork, and if he had given us a review of the disease as it exists on this continent, he would have added materially to

the value of the book. To those who do not possess special monographs this one will prove servicable, and we can commend it as containing a full *résumé* of the subject.

Experimental Pharmacology : A Handbook of Methods for Studying the Physiological Actions of Drugs.—By L. Hermann, Professor in the University of Zürich. Translated, with the author's permission, with notes and additions, by Robt. Meade Smith, M.D., Demonstrator of Physiology in the University of Pennsylvania. With thirty-two illustrations on wood. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Bros.

The more demonstrative all courses of lectures become—and this is the tendency of the age in the teaching of medicine—the more will students feel the want of a reliable guide to assist them in carrying on their examinations, by which they can confirm the observations they may make in the class-room. It has not yet been competent for any of our native schools to give practical demonstrations of the actions of drugs—we hope it soon will be—and when this comes, and our students before making these observations for themselves—and better still now in anticipation of this—we can highly recommend this book as furnishing all the necessary guidance with full directions, with reference to apparatus required, methods of procedure, etc., for investigating the actions of all important drugs upon muscles, nerves, glands, etc., and the functions of circulation, digestion, respiration, nutrition, etc. It has been edited with great care, and is well illustrated.

The Diseases of the Liver with or without Jaundice, with the Special Application of Physiological Chemistry to their Diagnosis and Treatment.—By George Harley, M.D., F.R.S., F.R.C.S., Physician to University College Hospital, etc. Illustrated by colored plates and wood engravings. Philadelphia: P. Blakiston, Son & Co. Montreal: Dawson Bros.

This work of Dr. Harley's upon these important disorders is

constructed upon a plan rather different from most of the systematic books on the same subject. The chemistry, physics and physiology of the liver form one of the early chapters, which is full of good teaching upon topics which make up the foundation for a correct understanding of the disturbances of this organ in disease. Much valuable information is to be obtained from the "general remarks on the signs and symptoms of Hepatic Disease," and on "treatment of Hepatic Disease." These are followed by a short account of that every day condition so universally called "biliousness," in which chapter many suggestive practical hints will be found. Jaundice is treated of in all its forms at very considerable length, its etiology receiving special attention. Abscess, cancer, hydatids, etc., are then treated of in order, and the affections of the gall-bladder have a section to themselves. From the known ability of the author, and the fact that he has for many years made a special study of the physiological chemistry of the excretions, renders his present work a valuable addition to the literature of this subject.

The Pharmacopœia of the United States of America.

Sixth decennial revision. New York: Wm. Wood & Co.

The sixth decennial revision of this important work made its appearance last November. The committee of revision being composed of almost equal numbers of medical men and pharmacists, it may be readily inferred that the interests of both were well discussed. The work appears to be a compilation of all medicines of any repute in the various States of the Republic; many of the remedies added are to us in Canada but little tried, but articles used with any degree of frequency by physicians of each State appear to have been accepted by the compilers.

The work of revision could have been no easy task, when we consider that 256 new articles have been added and 229 discarded, 106 of the latter being pharmaceutical preparations. It is with pleasure we see added such useful and, in many cases, well tried articles as salicylic and hydrobromic acids, pilocarpine, iodoform, chrysarobin, and many others that we could mention, yet we regret that so useful a manner of administering remedies,

as by suppositories, should have received so little attention ; all the suppositories of the former edition (nine in number) have been excluded. Five of the glycerites have also suffered the same fate, including the preparation of tannic acid. One great change we notice is that of giving the quantities by their relation to each other, instead of by weights and measures, thereby adopting the metric system where an opportunity offered,—a very useful one when well tried, and one that might be readily adopted in the now talked-of new revision of the British Pharmacopœia. Two new classes of preparations have been introduced—that of dry powdered extracts and triturations. The latter will be found very useful, and could be advantageously increased in number, but the compilers have provided for this by the introduction of a standard formula for all triturations—one grain of the active ingredient in each ten grains of the trituration.

The dry powdered extracts, or, as they are called by the compilers, "abstracts," are eleven in number ; they are introduced to "supply a demand which has arisen for dry powdered extracts," but whether they will prove of that advantage which is evidently expected is open to doubt. The process, similar in the first stages to that for the preparation of fluid extracts, is both expensive and laborious, and when complete, one grain of the result will only represent two grains of the crude drug, or two minims of the fluid extract. Among druggists there has long been felt a demand for officinal recognition of dry powdered extracts of known strength, extracts corresponding as nearly as possible to the pilular extracts of the pharmacopœia. Such extracts are now prepared in many large establishments for the sake of convenience in dispensing, such as Powd. Extract Aloes, Belladonna, &c.

Upwards of thirty fluid extracts have been added, showing the esteem in which this form of preparing drugs is held by the profession ; the strength of these are made of a definite standard, 100 grammes of the crude drug making 100 cubic centimetres of the fluid extract. Strange to say, elixirs, so popularly used and many so elegant in their preparation, and having their origin in the States, are, with one exception, entirely omitted.

Cotton-seed oil takes the place of olive oil in the liniments. Except in the case of Lin. Camphoræ, camphor being more readily soluble in that oil, the advantage of the change is doubtful.

The compilation of tables of "thermometric equivalents," "percentage and specific gravity," "saturation," and others, will be found very useful, and too much cannot be said in praise of them. We notice the omission of all processes for the manufacture of chemicals, the physical characteristics only being described, and tests for their identity and purity being given. This is in accordance with the general principles laid down on page 22 to be followed in revising the work, and on the next page is another of these rules that "all doses shall be omitted." Whether this be a wise rule or not is open to grave doubt. For our part we think that the compilers of the Pharmacopœia—the text-book of both medical men and druggists—should be the responsible persons to lay down the doses of each article. These articles have each passed in review before them; many of them do not appear in works likely to be in the hands of students, and to such the Pharmacopœia has always been the harbour of refuge.

On the whole, we may certainly say that the work is the best yet produced, and deserves at the hands of physicians and druggists an impartial trial.

Books and Pamphlets Received.

A Manual of Auscultation and Percussion, Embracing the Physical Diagnosis of Diseases of the Lungs and Heart, and of Thoracic Aneurism. By Austin Flint, M.D. Third Edition; revised. Philadelphia: H. C. Lea's Son & Co. Montreal: Dawson Bros.

Handbook of Medical Electricity. By A. M. Rosebrough, M.D., Toronto.

Manual of Gynæcology. By D. Berry Hart, M.D., F.R.C.P.S., and C. A. Barbour, M.A., B.L., M.B. Vol. II. New York: Wm. Wood & Co.

The Temperance Lesson Book. A Series of Short Lessons on Alcohol and its Action on the Body. By Benj. W. Richardson, A.M., M.D., LL.D., F.R.C.S., etc. Thirty-eigth Thousand. London: The National Temperance Publication Depot.

Transactions of the American Medical Association. Vol. XXXIII. Philadelphia: Times Printing House.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, March 2nd, 1883.

T. G. Roddick, M.D., 1st Vice-President, in the Chair.

Dr. Trenholme exhibited a *fibro-cystic tumor of the uterus.* The patient, a well-formed, healthy girl, 39 years of age, has always had good health. About eight years ago she discovered a tumor in right side, which slowly increased for five years, when it took on rapid growth. It became smaller after each menstrual period till the last three years; since then has never diminished at all. At this time she noted that the tumor moved in one night from the right side to the middle of the body. The result of several careful examinations was that there were two tumors. The one on right side being lowest and and most firm to the touch, and fluctuation not felt. The left, the larger, was felt to be moveable from the other and fluctuation was felt, but not distinctly. A well-marked sulcus existed between the growths; both were of even general contour. Per vaginam the os was found to be high up, and, so far as the finger and sound could indicate, showed the lower growth was uterine, and probably sprung from back part of the uterus. The sound could be introduced with much difficulty only 2½ inches. The left tumor it was thought might be ovarian, and, if so, could perhaps be removed, and thus afford relief to the great sufferings of the patient, and which she said were at times dreadful to endure, and of late rendered her life so miserable that she willingly subjected herself to the operation, though she was more than well apprised of the risk she ran, and was told that she was as likely to die as to recover,—the probability of recovery (should the uterus require to be removed) being about equal. After preliminary attention to the state of bowels, etc., assisted by Drs. Hingston, Robillard, Gardner, Armstrong, Young, Henderson and Wood, the operation was begun at noon on the 19th February, and lasted two hours fifteen minutes. The nature of the growths were now apparent, and the amputation of the stump was followed by considerable bleeding, and

some vessels secured with difficulty. Hemp ligatures were used internally, except one silver suture to close the os internum. The outer wound was secured by deep silver wire sutures, superficially by horse hair. The patient soon recovered consciousness, and though vomiting supervened she made a gallant fight for life, but died on the 5th day, in the evening, from exhaustion, due to uncontrollable vomiting. The temperature and pulse were little above the normal till toward the end of life.

The following morning, fifteen hours after death, Dr. Osler kindly made the *post mortem* examination. The following are his notes: Abdomen distended. Union at the lower and upper portions of the incision, and of the skin in the middle portion. Coils of intestines reddened and sticky, but no lymph over the membrane. There is no peritoneal effusion. Parietal layer is reddened from recent sub-peritoneal extravasation. Last part of ilium adheres slightly to the abdominal walls. On left side of the pelvis the ligated broad ligament is seen; its surface is rough and irregular, and not covered with any membrane. By the side of the rectum is a space containing dirty bloody fluid. The stump of the uterus adheres to the rectum. The walls of the pelvis are in good clear condition. Stomach, liver and kidneys healthy.

A committee consisting of Drs. Gardner, Osler and Armstrong, was appointed to examine the tumor and report to the Society.

Dr. George Ross spoke of the importance attached to investigation into the cause of death in cases of abdominal operations. He had recently had a conversation with Dr. Thomas in New York, and agreed with him in the opinion that patients may die from septicæmia without the signs of high temperature, chills, etc., from an overwhelming dose of poison being absorbed,—the symptoms in those cases being more like those of hemorrhage.

Leucocythemia.—Dr. G. Tillerie Ross reported the case. *(See page* 532.)

Dr. Geo. Ross spoke of the rarity of this disease in this city and

in America, as compared with other countries ; he had only seen one case in the Hospital in ten years, but has seen others in private practice, whereas several cases of the rarer Hodgkins' disease had come under his care.

Dr. Osler said the late Dr. John Bell was the first to report a case in Canada. The points of special interest in the case just reported, were the enormously distended heart and venous system. As there were no adhesions it might have been a good case for removal of the spleen. A successful operation was recently performed in Italy.

Dr. Smith mentioned a case of leucocythemia under his care, which had been considerably relieved by treatment, in which iron and arsenic were employed, together with generous diet and inunctions of mercury.

Dr. George Ross said the remarkable temporary improvement seen in blood diseases could not be always attributed to treatment. Sometimes in pernicious anæmia, such an improvement may be noticed as to make one think that an error in diagnosis had been made till they relapse and terminate fatally. He had lately such a case in the Hospital. Under arsenic and iron, the patient got well enough to resume work, but returned to the Hospital and died. He has also noticed this temporary improvement in Hodgkins' disease.

Dr. Roddick exhibited a photograph of a child shewing *recurrence of lymphadenomatous glands* after removal by him.

Stated Meeting, March 16th, 1883.

T. G. Roddick, M.D., Vice-President, in the Chair.

Dr. Osler exhibited the following pathological specimens :—

Membranous cast of Windpipe and Bronchi.—An unusually extensive cast of the air passages taken from a patient of Dr. Blackader's who died of diphtheria. Tracheotomy had been performed, but death took place from the gradual filling of the bronchi with the exudation. The glottis was completely occluded, and the membrane was so firm and consistent that it was removed entire from the rima to the tubes of the 3rd dimension, the tracheotomy orifice perforating it about 1½ inches below the rima.

Chronic Bright's Disease.—The patient had been ill for six weeks with dropsy and other signs of chronic renal trouble. The fluid in the peritoneum and pleural sacs was milky, and a specimen of it was shown by Dr. Ross at a former meeting. The kidneys were large, pale and smooth ; cortices swollen, and presented many opaque areas of fatty degeneration. Examination showed the interstitial tissue to be also somewhat increased, and many of the Malpighian bodies were atrophied.

Aneurism of Pulmonary Artery in small cavity.—Taken from patient with chronic phthisis, who had had profuse hæmoptypsis, which had been checked, but death followed in 48 hours from exhaustion. In the upper part of the right lower lobe there was a small cavity filled with clots, and projecting from the wall was an aneurism the size of a large pea. This had ruptured, and was filled with pretty firm clots.

Dr. Osler called attention to the frequency of these small aneurisms, and to the fact that the fatal hæmoptysis in chronic phthisis is very often due to their rupture.

Acute Tuberculosis of Lung and Spleen.—A. M., aged 26, under care of Dr. Geo. Ross, admitted into hospital with symptoms suggestive of some low form of blood poisoning, with severe pain and tenderness in right side of abdomen. No physical signs of lung or heart trouble. A year before, had symptoms of chest trouble, apparently recovered from, with exception of loss of weight and night sweats. While in hospital he failed rapidly, with irregular temperatures. One week before death, physical signs began to develop over front of left chest, slight dullness, feeble breathing, and fine râles ; this condition soon extended over the whole of both lungs, increasing rapidly in intensity. At autopsy, lungs crepitant, except at apices, where they are firm ; both organs universally stuffed with miliary tubercles, largest in upper lobes, making small caseous nodules size of split peas. This condition most marked at apices, in which are seen small old cavities. Spleen three times normal size, presenting numerous miliary tubercles in its substance. Kidneys average size ; through cortices are several small scattered tubercles. Under the microscope, in spots, a good deal of proliferation of

epithelium is seen in the tubes and around the Malpighian capsules. Liver normal. Brain not examined. Careful examination showed no sign of disease in right side of abdomen.

Lead Poisoning.—Dr. Girdwood read the reports of two cases occurring in the practice of Dr. Groves, Carp, Ont. The first was that of a widow, aged 34, who sent for the doctor November 30th, 1880. She was suffering from pain in abdomen; no tenderness on pressure. Appetite bad, much thirst, fœtor of breath, tongue coated, constipation. Treated her for colic. Was seen again in three days. Pain worse. Now found blue line on gums. Diagnosed lead poisoning. After much trouble, the source was traced to the well, or rather the pump. Six months before, a large piece of lead had been placed on the valve to weight it down, and the water, being very pure, acted upon the lead and made a solution. Other members of the family had been slightly affected by it. All recovered completely after the cause was removed. The second case was a Mrs. C., aged 37, who sent for Dr. Groves Oct. 19th, 1882. She complained of abdominal pains, also pains in the back and limbs; had been so affected for two weeks before sending for the doctor. Her tongue was heavily coated with a dark fur; blue line on gums; inside of cheeks bluish-black; countenance anxious; face pale, subicteroid. Abdomen slightly tympanitic; no pain on pressure. Pain in abdomen was paroxysmal and lancinating in character, and seemed to shoot into the back and down lower limbs. Complained of metallic taste, fœtor of breath, and annoying eructations. No appetite; bowels constipated. Urine scanty and dark-colored. Extensors of forearms paralyzed. Wrist-drop more marked on right side. Was much emaciated; raising head off pillow caused nausea. Pulse 120; temperature 102°. Treatment: Gave first a brisk purgative, and left mixture of Potass. Iodid. v grs. three times a day, and Chlor. Anodyne to relieve pain. After examining the well, cooking utensils, etc., at last came across a jar of vinegar, which was examined, and found to contain a large percentage of lead acetate. On breaking the jar, a rounded elevation was seen on the inside of its bottom. This prominence was eaten into by the vinegar. The jar and

vinegar had been purchased on October 4, '82. After questioning, he found his patient had partaken largely of this vinegar. In connection with these cases, Dr. Girdwood said: Dr. Groves sent me, in December last, a sample of vinegar which he wished me to analyse for lead, stating that he had a case of lead poisoning. I examined the sample of vinegar, and found it to contain 2.01 per cent. of acetate of lead. He also sent me a piece of broken pottery, which he informed me was a portion of the bottom of the stone jar which had contained the vinegar. I found this jar had been glazed with litharge, or oxide of lead, and that it had been acted upon by the acetic acid and the whole surface eroded. In these two cases of lead poisoning there is considerable interest in the sources whence the lead was taken into the system, and these point to the necessity of being constantly alive and searching all possible and impossible causes or avenues by which poison may be introduced into the system. In the first case, the danger of storage of water, more especially water which is pure, in leaden cisterns or carried through leaden pipes is brought prominently out. Had the water contained any sulphate, an insoluble sulphate of lead would have been found, which would have been inert. In the second case, the necessity of greater care in guarding food of all kinds from contamination is shown. Had this sample of vinegar been adulterated, as it frequently is, by 3 per cent. of sulphuric acid, this case of poisoning would not have come to light, because the sulphuric acid would have formed an insoluble sulphate, which would have stayed further action. But from not having any sulphuric acid in it, the acetic acid gradually acted on the oxide of lead and dissolved it. Another point of interest is the fact of increased temperature and increase of pulse, symptoms which I fail to find recorded in authors who speak of the symptoms of poisoning by lead. They also exhibit the cumulative effect of the poison, the gradual introduction of the poison, at last producing the set of symptoms which lead to the diagnosis of lead as the poison. And the poison acting on the liver preventing the secretion of bile and all the train of symptoms indicating hypochondria, depression of spirits, fear of impending danger, being well marked, especially in the latter

case. And the gradual diminution of the symptoms after the cessation of the cause. These cases also determine, as far as they go, that the amount of lead sufficient to produce these symptoms is eliminated from the system in the course of two or three weeks. It is a pity that the urine in these cases was not examined, so as to ascertain the exact period at which it ceased to appear, and so have given a little more definite criterion of the time it takes to eliminate lead from the system. I scarcely see what steps can be taken legally to prevent a recurrence of these accidents; but it will be well to diffuse the knowledge that lead used for water storage, especially in a country where good soft water is common, is liable to be dangerous. And that it is customary to use lead in the glaze of common earthenware, and that such a practice is fraught with danger to the public.

Extracts from British and Foreign Journals.

Unless otherwise stated the translations are made specially for this Journal.

Two Cases of Colotomy.—Although this operation is very frequently performed at the present time, it is not easy to obtain a description in the books which will serve the purpose of a useful guide to the surgeon who is about to undertake his first case of this kind. The best description in the English language is furnished by Allingham, so far as the writer is aware, and he is freely quoted by Bryant. A painstaking and accurate account is given by Koenig. Allingham's rules are: to make an incision beginning one and one half inches to the left of the first spine below the last rib, and running five inches obliquely downwards and forwards across the space between the last rib and the crest of the ilium. Some writers content themselves with saying that the middle of the incision should correspond with the highest point of the *crista ilii*. The length of the incision is occasionally given as three inches. This is about the length of that drawn in Bourgey's plates of Amussat's operation. Packard, in the American edition of Holmes, considers this length sufficient. It is his custom, he informs me, to begin the incision at the depression made by the edge of the quadratus lumborum muscles. Inasmuch as the bowel lies at

the edge of the muscle, this would bring the objective point near the beginning of the preliminary incision and not under the centre, as it should be. Moreover, some anatomists affirm that the depression supposed to be caused by the quadratus is really produced by other muscles. Allingham calls attention to the fact that it is sometimes quite difficult to find the bowel, and gives as a guide the direction to draw a line from the anterior to the posterior spinous processes, to extend a line vertically from a point one half inch behind the centre of this line, and it will be found to lie directly over the bowel. The bowel may be opened in the groin according to Littré's method, and modern surgery has deprived this operation of its principal danger, the opening of the peritonæum. Another method of getting at the colon, described by Fine, consists in making a vertical incision from the eleventh rib to the crest of the ilium through the abdominal walls and opening the colon within the peritonæum. The precautions sometimes given not to open the bowel in these operations until it has become glued to the lips of the incision seems hardly necessary.

The first case was that of a German girl, twenty-three years of age, who entered the Massachusetts General Hospital with symptoms of disease of the rectum of one year's standing. She was suffering great pain in defecation, and a digital examination showed the lower rectum to be almost completely obstructed by an indurated growth. The patient was etherized a few days later, and the constriction relieved by an incision which completely divided all tissues between the anus and coccyx, including the lining of the bowel and skin. Great relief followed, but in a week or two the symptoms of stricture returned, and it was found that the disease had already extended above the incision. Colotomy was performed on May 24th, Allingham's directions being carefully followed. The bowel was found without difficulty, was caught up by two loops of thread, and the incision stitched together around it. The colon was then opened, and after a very abundant fæcal discharge had taken place was stitched to the edges of the opening left for that purpose. The operation was done with antiseptic precautions, as a slight

attack of erysipelas had followed the previous operation. Drainage tubes were inserted at each end of the incision, and a dressing of oakum folded in carbolized gauze was placed over the wound and changed as often as necessary. Except a slight erysipelatous blush lasting a few days recovery was uninterrupted, and the patient was discharged from the hospital June 24th, with the wound entirely healed. There was no inconvenience from leakage from the bowel, although occasionally a small amount of fæcal matter escaped with the morbid discharges from the rectum. There were two natural movements from the bowel daily, and there was complete relief from the previous suffering. During the summer the patient reported herself at the hospital. The movements continued to be well-formed and regular. The disease continued to progress, and she died on January 1st, having been obliged to resort to opiates only a few days before death.

Colotomy was performed in the second case for congenital absence of the rectum. The child, a patient of Dr. W. A. Dunn, was born two days before, and all attempts to open the bowel through the anal orifice were unavailing. The so-called paradox of M. Huguier occurring to my mind, namely, that in infants the sigmoid flexure is in the *right* groin, I selected that position, found the distended bowel without difficulty, and evacuated a large amount of meconium, relieving the enormously distended abdomen. All symptoms were speedily relieved, the child nursed well, and the wound healed without any indications of unusual inflammation. A progressive emaciation soon set in, which continued in spite of the baby's ability to nurse well, and death occurred on the fourteenth day. Unfortunately, Dr. Dunn was unable to procure an autopsy and settle the point whether the ascending or descending colon had been opened. Taking into consideration the fact that it has been shown that the position of the sigmoid flexure described by Huguier is found in a comparatively small percentage of cases, and that when the ascending colon is opened marked emaciation occurs, as has been pointed out by some writers, it seems quite possible that the ascending colon was opened in this instance, although the

rapid and abundant discharge of fæces made it seem probable at the time of the operation that the opening had been made near the fundus of the cul-de-sac.

In looking up the literature of this subject after the operation, the proposition of McLeod struck me most favorably, and that is, to perform abdominal section when the rectum is wanting, free the end of the bowel from its connections, and, having emptied it, bring it down and stitch it to the anal opening. This is certainly a severe operation, but it seems to me preferable to all other alternatives. The treatment of cancer of the rectum deserves a word in connection with the case first reported. In this neighborhood it has been the custom to adopt chiefly an expectant method, the stricture, if marked, being relieved by the passage of bougies; in England colotomy is almost universal; in Germany extirpation is largely resorted to. A linear division of the stricture, which I have performed in a number of cases, brings only temporary relief. A radical operation can, of course, only be attempted with reasonable hope of success in the earlier stages of the disease, but it is important to recognize the fact that the terrible suffering peculiar to cancer in this locality can be greatly relieved by an opening in the bowel at some point above.—*Dr. J. Collins Warren in Boston Med. & Surg. Journal.*

Electricity v. Hangings.—A contemporary, in drawing attention to a proposal of Mr. Lane Fox in a recent issue of the *Zoophilist*, to employ a form of apparatus known to electricians as the micro-farad condenser for the destruction of worn-out horses and domestic animals, takes the opportunity of drawing attention to the barbarities attending the present use of the long drop in judicial executions: and also suggests that "far less contrivance and money than were expended on the Peltzer case would suffice to arrange a murder by electricity, which would in all respects resemble a death by the visitation of God," by which we presume is meant a death from natural causes. Murder is so much a fine art, or at all events an application of science, in the present day, that this suggestion—perhaps not a novel one—might well have been spared, even in

the pages of a medical journal, where it is little likely, we hope, to catch the eyes of would-be murderers. We believe that should murder by electricity ever be practised, the resources of medicine and science will prove equal to the detection of the agent employed. The accidents that may be expected to result from the extension of electric lighting, will doubtless soon afford medical men the opportunities of becoming familiar with the appearances resulting from death from electricity. Mr. Lane Fox's proposal is a humane one, but we question whether it will meet with serious recognition. It is applicable to horses and pet animals only; and is inapplicable to animals the flesh of which is to be used for food. The plan is too complex, and involves, in killing a horse, the following elaborate preparations: the fitting of an iron plate into the stable-floor, and the connection of this with the negative pole of a condenser formed of alternate layers of tinfoil and tissue paper soaked in paraffin. The condenser is then to be charged from an ordinary coil to its full capacity, so as to be capable of producing a one-inch spark. The animal to be killed is to have its head, feet, and legs sponged with salt water, and is then to be placed on the iron plate, and touched on the head by a brass knob attached to an insulating handle, and connected with the positive pole of the condenser, when it at once falls dead. Death is asserted to be painless. Probably it is so; but of this we know, and can know, nothing. Our readers will perhaps be of opinion that by this method it would be more troublesome and costly to kill a worn-out cab-horse than to hang a criminal; not to speak of the operation being by no means devoid of danger to the operators. The feasibility and advisability of judicial executions being carried out by means of electricity is one, nevertheless, which is well worthy of consideration; and certainly, now that executions take place in private, and the criminal at the moment when the drop falls becomes immediately removed from the view of all but the executioner, there are additional reasons why the mode of carrying out the dread capital sentence of the law in Britain should be revised. Not to go back to earlier atrocities, the scenes at the execution of the man Taylor, at Wandsworth, and

of Myles Joice, at Galway, respectively, are reported to have been of the most revolting description. It would appear that the long drop (the length at present used is stated to be 9 feet) does not bring about instantaneous death; and causes, sometimes, perhaps, prolonged and unnecessary suffering. It is, then, well worth consideration whether the use of electricity, or the simpler mode of strangulation recently proposed by Dr. Hammond, of New York, should not be substituted for the present system. Dr. Hammond's method has the advantage over the electrical, that we have the personal voucher of a man of his high reputation that the sensations of the strangled man, up to the moment when unconsciousness supervenes, are rather pleasurable than painful. So long as execution is required by our law, it behooves the authorities to carry out the sentence in a manner as little revolting, and as painlessly, as is possible.—*Brit. Med. Journal.*

Kairine.—In the attempts to produce quinine, synthetically, now making in Germany, various new products which have been employed medicinally, have been brought forward. Although a true quinine has not thus far been accomplished, a near approximation to it has been made. Quinoline or chinoline is one of these. Recently, however, Dr. Fischer (*Berliner klin. Wochen.*, No. 45, 1882) has produced a phenol, to which he has applied the term *kairine* for short, although its true name is *oxy-quinoline—methyl-hydride* in chemical language. The salt which has been employed medicinally is the hydrochlorate. It has no irritant qualities, and in the normal state causes no obvious disturbance, All the members of the phenol group are antiseptic and antipyretic. The antipyretic stands in a nearly constant ratio to the antiseptic action. This fact is strongly suggestive, for if the power to destroy the organisms of disease or septic ferments, is the source of the antipyretic action, it is in a high degree probable that the febrile action is a consequence of the multiplication and growth of germs or ferments. The action of antiseptics lends support to the parasitic or zymotic theory of the infectious diseases.

Besides kairine, there have been introduced kairoline, and in

addition to resorcin, quinoline and pyrocatechin, all members of the phenol group, and all possessed of antiseptic and antipyretic effects. We are confident that the time is not distant, when that most valuable of all antiseptics and antipyretics—quinine—will be produced in the laboratory of the chemist.—*Med. News.*

Woman Attached to a Tumour.—A recent number of the *Medical Record* contains engravings from photographs of a woman who was afflicted with a tumour weighing eighty pounds. It was attached to the abdomen, and the picture shows the patient in a sitting posture, holding in her arms and on her knees a large bundle, which formed her undesirable appendage. After much entreaty from the poor woman that an operation for her relief might be tried, the surgeons of the Cincinnati Hospital finally consented; and Dr. N. P. Dandridge performed the hazardous work with great skill, being assisted by Dr. E. W. Walker and the hospital staff, in the presence of the medical class and a large number of neighboring physicians. But the shock to the patient was very profound, and her inherent strength not sufficient. She survived a week after the operation. This was a subcutaneous fatty tumor, one of the largest ever known. It was thirty-five inches long and sixty-seven and a half inches in greatest diameter—nearly as large as a barrel of flour.

Cure of Squint without Operation.—In the early stages of a convergent strabismus, before the internal rectus muscle is permanently contracted, Dr. Boucheron (*Schmidt's Jarbucher*, January 17, 1883) claims that a cure is possible without operation. He states that, as a convergence is caused by efforts of accommodation for near objects, if we take away the power of accommodation, squint will not occur. He maintains a constant mydriasis by the instillation of atropine night and morning. A cure is usually obtained in two or three weeks. If atropine is not well borne, other mydriatics, such as duboisia, may be used. In nine cases of intermittent strabismus the author obtained eight cures by this method.—*Medical Record.*

CANADA

Medical and Surgical Journal.

MONTREAL, MAY, 1883.

CHANGES IN McGILL.

We have already announced that Prof. Wright has resigned the chair of Materia Medica in McGill College. It will be remembered that, during the past session, considerable friction was found to exist between the professor and his class. A settlement of grievances was finally arrived at after some trouble, and the students attended till the session closed. No doubt the resignation has been to some extent induced by the knowledge of the reigning discontent. It must be regretted that such circumstances should have arisen in connection with one who has been so long connected with the school, and who in the past has done such good service on many occasions in its cause. The vacancy created has been filled by the Faculty recommending the name of Dr. James Stewart, of Brucefield, Ont. This recommendation has been approved by the Board of Governors of the University, and only awaits the sanction of His Excellency the Governor-General. It is believed that the very best possible selection has been made. Dr. Stewart has for many years taken great interest in all matters pertaining to the subject of drugs and their actions, and has been a frequent contributor in this department to the Medical Societies and Journals of papers which have excited attention and shown marked ability. He is at the present time in Vienna, where he has been taking a special course upon practical experimental therapeutics. From our personal knowledge of Dr. Stewart we think his success as a teacher is assured, and that the Faculty is to be congratulated upon his acceptance of the office.

Still another of the older members of the Faculty of McGill

College has resigned, viz., Prof. MacCallum, who has so long and so successfully presided over the department of Obstetrics. An extended and important private practice had been making such calls upon both the doctor's time and energies, that he found it to be impossible to continue longer the rather laborious work of daily teaching. Dr. MacCallum has now taught midwifery with much success for the past 15 years, besides having the care of the University Lying-In-Hospital. The Faculty part with regret from an able and zealous colleague who has ever faithfully performed all duties entrusted to him by the University, and it is expected that he will be named Emeritus Professor. This chair will in future be divided into two parts, the one including Obstetrics and the diseases of infants, and the other Gynæcology. The former department will be undertaken by Dr. A. A. Browne, who has for some years acted as Dr. MacCallum's assistant for practical demonstration in the Lying-In Wards, and as Lecturer in the summer session. Dr. Browne is at present in Europe intending to devote himself to the special study of obstetrics in London and Vienna during several months.

Prof. Gardner, who has hitherto held the chairs of Medical Jurisprudence and Hygiene, has resigned these, and will become Professor of Gynæcology. He has recently renounced general practice and devotes himself entirely to the special treatment of women. He is well known to the readers of this Journal through his quarterly compilation of the recent writings on Gynæcology.

Dr. Geo. Wilkins, for several years professor of pathology in the medical department of Bishop's College, has accepted the chair of Medical Jurisprudence. He is recognized as an experienced lecturer, a good microscopist, and an energetic investigator. It is confidently anticipated that a thorough and interesting course will be given from this chair.

Dr. Richard MacDonnell, assistant Demonstrator of Anatomy, will, in addition to these duties, be made Lecturer on Hygiene.

CHANGES IN THE SCHOOLS.

KINGSTON.—Dr. Saunders, to take Clinical Surgery; Dr. McCammon, Clinical Medicine; Dr. W. H. Henderson, Histology and Curatorship of the Museum.

BISHOP'S COLLEGE, MONTREAL.—Dr. Wood, transferred from Chair of Chemistry to that of Pathology; Dr. Armstrong, from Chair of Anatomy to that of Physiology. Dr. Young takes Chemistry. Dr. Trenholme, the original Professor of Midwifery and Diseases of Women, has joined the school again as Professor of Gynæcology. Dr. Foley, the Asst. Demonstrator of Anatomy, succeeds Dr. Armstrong. Dr. McConnell, the Lecturer on Botany, takes Materia Medica; and Dr. H. L. Reddy has been appointed Professor of Therapeutics.

WESTERN UNIVERSITY, LONDON, ONT.—Dr. Wishart has been appointed Professor of Clinical Surgery; Dr. McGuigan, Registrar; W. Saunders, Esq., Treasurer; Dr. Arnott, Representative in the Ontario Medical Council; and Drs. Arnott, Waugh and W. Saunders, Executive Committee.

MEDICAL EXAMINATIONS.

The following completes the list of examinations in Canadian Universities and Examining Boards:—

QUEEN'S UNIVERSITY.—M.D.C.M.—W. G. Anglin, C. Clancy, J. Cryan, L. Davis, H. M. Freeland, D. C. Hinkey, J. F. Kidd, G. S. McGhie, A. McMurchy, T. A. Moore, T. A. Page, R. S. Smith, W. Young.

VICTORIA UNIVERSITY.—M.D.C.M.—J. M. Jackson, R. Hearn, A. D. Watson, H. S. Clerke, W. Cuthbertson, E. M. Hewish, J. S. Draper, S. S. Stewart, J. E. Case, W. Jaques, F. P. Drake, A. L. Brown, Augusta Stowe, C. S. Grafton, George Wyld, J. J. Wild. C. E. Cochrane, J. H. C. Willoughby, Wm. Kennedy.

TORONTO SCHOOL OF MEDICINE.—*Fourth Year.*—W. J. Robinson, (Scholarship); J. M. Jackson, (Honors).

Third Year.—R. Hearn, (Scholarship); J. W. Clerke, (Honors).

Second Year.—L. Carr, (Scholarship); H. Bascom, J. H. Howell, (Honors); J. G. Sutherland, G. A. Carveth, W. A. Goodell, J. S. Freebourne, J. R. Harvie, C. W. Hunt, A. C. Krick, and D. Ellis.

First Year.—D. R. Johnston, (Scholarship); 39 candidates passed the first year's examination.

COLLEGE OF PHYSICIANS AND SURGEONS, ONT.—*Final for License.*—W. G. Anglin, F. D. Bates, R. W. Belt, W. D. M. Bell, J. Bray, M. K. Collyer,

H. R. Casgrain, H. S. Clerke, T. E. Case, W. H. Carleton, C. W. Chafee, J. Cryan, W. Cuthbertson, W. J. Derby, F. P. Drake, W. F. Dickson, W. J. H. Emory, W. F. Freeman, R. M. Fairchild, R. S. Frost, J. B. Gullen, C. M. Gordon, J. E. Hansler, R. Hearn, R. Hislop, D. C. Hickey, J. M. Jackson, W. Jaques, J. F. Kidd, F. Krauss, W. J. Lepper, T. D. Meikle, J. A. Meldrum, S. W. McConochie, A. McMurchy, E. B. O'Reilly, J. C. Rattray, W. A. Ross, T. H. Robinson, W. J. Robinson, E. A. Spilsbury, Augusta Stowe, F. H. Sawers, J. D. Wilson, J. B Whitely, E. R. Woods, J. W. Ray.

Primary.—W. D. M. Bell, G. A. Bingham, J. A. Burgess, F. Beemer, Elizabeth Beatty, W. M. Brown, G. A. Carveth, J. A. Couch, J. D. Courtenay, F. A. Cane, G. A. Cherry, J. M. Cochrane, H. S. Clerke, T. E. Case, C. W. Chafee, W. J. Derby, P. A. Dewar, J. S Draper, H. Duff, J. E. Elliott, D. W. Everts, T. E. Eede, W. J. H. Emory, R. M. Fairchild, J. Fergusson, G. Fierheller, W. A. Goodall, W. J. Gunne, C. M. Gordon, H. H. Hawley, E. F. Hixon, A. R. Harvie, J. H. Howell, C. W. Hunt, J. Herald, A. R. Hanks, Fred. Harkin, E. A. Hall, W. S. Harrison, R. Hislop, D. C. Hickey, G. L. Johnston, D. O. R. Jones, F. H. Johnston, A. B. Kinsely, C. A. Krick, J. H. Knight, F. Krauss, H. D. Leitch, A. D. Lake, R. J. Lockhart, J. R. Logan, T. W. Murray, H. S. Martin, D. Minchin, Alice McGillivray, M. C. McGannon, T. Ovens, J. O. Orr, J. J. Paul, J. R. Phillips, J. W. Patterson, G. F. Palmer, W. N. Robertson, R. F. Ruttan, J. C. Rattray, R. L. Stewart, S. Stewart, J. G. Sutherland, Elizabeth Smith, J. E. Sterling, C. Trow, H. E. Webster, A. B. Wilson, J. A. Watson, G. S. Wattam.

College of Physicians and Surgeons, P. Q.—*Final for License.*—H. A. Lafleur, E. H. Blackader, Wm. G. Stewart, A. W. Gardner, — Beique, Wm. Christie, Robert Kirkpatrick, Joseph Langlois, George C. Stephen, A. Couturier, Alex. Corvie, Theo. Mayrand, C. V. Poitras, Joseph F. Triganne, Adolphe Guy, Chas. J. Edgar, Jos. Edge, J. G. Lamarche, Paul Briere, L. J A. Mignault, Joseph Cinq-Mars, Henri Marchand, J. B. Richard, Thos. C. Blondeau, C. A. Dugas, Geo. W. Lecombe, Damase J. Page, Edmond Bittner, Wilfred Joyal, L. Rochette, Honore Garceau, Alphonse Hudon, Elzear Lebrecque, Charles V. Marsil, Joseph Michaud, Pierre Pelland, and Pantaleon Pelletier.

Pharmaceutical Association, Province of Quebec.—The examination for certificates was held on the 25th April, when the following gentlemen were successful :—

Major Examination.—Chas. E. Scarff, Alph. Davidson, Ed. Leonard, Alexis Robert, Ernest G. Swift, and Adhelm Dugal. One candidate failed.

Minor Examination.—A. E. Holden, L. Flanagan, Joseph H. Nault, R. A. Kerry, A. R. Reid, F. Baker, J. L. Beaudry, W. Purchard, M. B. Rice, and E. F. G. Daniel. The first two tied. Seven candidates failed.

The Board of Examiners is constituted as follows :—Alex. Manson (chairman), H. R. Gray, J. D. L. Ambrosse, H. F. Jackson, R. McLeod (Quebec), F. E. Gauvreau (Quebec), and Wm. Ahern, Secretary and Registrar.

—For the vacant positions of Resident Medical Officers in the Hospital, left by the retirement of Drs. MacDonald, Duncan and McLean, there are four candidates, all members of the graduating class of '83 (McGill),—Messrs. Gray, Hopkins, Gardner and Henry. The examination for the positions took place on Monday the 7th, and election will be held on the 17th, at the annual meeting of the Governors.

—Of 77 candidates at the preliminary examination of the College of Physicians and Surgeons for entrance to the study of medicine in the Province of Quebec, held on the 9th inst., 37 passed, 27 were rejected, and 13 rejected on certain subjects. During the past three years there has been a good deal of dissatisfaction in certain quarters at the large proportion of rejections at this examination, often much larger than on this occasion. We feel sure that it will do good, and in time the students will come up better prepared. We have been told by one of the examiners that the French students are most frequently *plucked* in French and the English students in English.

—We have received a copy of the report furnished to the Provincial Health Board, by Dr. Smellie of Prince Arthur's Landing, on the epidemic of small-pox on the Nepigon section of the C. P. R. The disease broke out early in January, and of twenty-five attacked—19 men on the Road and 6 persons in Prince Arthur's Landing—five died. A rigid quarantine was established and maintained until April 2nd, when the men in the infected camps were thoroughly washed, supplied with new outfits, and the camps burnt. Dr. Smellie took the disease early in the outbreak, and his assistant, Dr. McCammon, proved equal to the occasion.

—Mr. Barwell, the accomplished surgeon of Charing-Cross Hospital, has of late been strongly advocating the employment of white lead paint in the treatment of erysipelas, having had some half-dozen cases in which it was used with the most gratifying results. He does not lay claim to any originality in connection with this method of treating erysipelas, but simply revives an old remedy employed by Mr. French some twenty years ago.

The paint is applied by means of an ordinary brush, and seems to act simply by excluding the air. Mr. Barwell has not found it necessary to employ internal treatment of any kind. In some of the cases the urine was tested for lead, but the results were invariably negative.

Obituary.

John A. Stevenson.—The profession of London, Ont., has lost one of its most active members by the death of this gentleman on the 28th ult. He was the son of Judge Stevenson of Simcoe, Ont., entered McGill College in 1869, and graduated in 1873. He began practice in London with Dr. Fraser, and quickly won the confidence of the profession and the public. Last year, when the Medical Faculty of the Western University was organized, he took a very active part in the promotion of the new school, and was the Lecturer on Therapeutics and Secretary of the Faculty. He overtaxed his energies, and symptoms of pulmonary disease became manifest. Dr. Stevenson married a daughter of Vice-Chancellor Proudfoot of Toronto, and his wife and two children are left to mourn his loss. To them and to his brother, Dr. R. A. Stevenson of Strathroy, we extend our sincere sympathy. The class of '73 has lost one of its most popular members.

Joseph A. Whyte.—Dr. Whyte was a native of Charleston, S.C. After having served on the Confederate side through the American war, he came to Canada and studied at McGill College, where he graduated in 1870. He subsequently, in Edinburgh, received the qualification of M.R.C.S. He practised first at Sherbrooke, and for the past five years in Montreal. He had for some time suffered from heart disease, of which he died in this city on the 25th April, at the early age of 40 years. His kindly disposition made him many friends, and his death will be heard of with regret by many of his old classmates.

Alexander Chisholm.—We regret to have to record the death of this promising young physician, at Alexandria, Ont., on the 6th inst. He was a native of Lochiel, Ont., entered McGill

College in 1874, and graduated in 1878. After practicing a short time he went to Great Britain and took the diplomas of the Edinburgh Colleges, and on his return settled in Alexandria, where he rapidly acquired a large practice.

Surgeon-General Barnes—died at Washington on the 5th ult., aged 66. He was a graduate of the University of Pennsylvania, and entered the army in 1840. His name will ever be associated with three great undertakings—the Medical and Surgical History of the War of the Rebellion, the Army Medical Museum, and the Library of the Surgeon-General's Office.

B. H. Leprohon—of Joliette, Q., died on the 24th ult. after a long and painful illness. He was an *alumnus* of the Victoria School, and for many years had been Sheriff of the county. He was a cousin of Dr. J. B. Leprohon of this city.

William Farr—the celebrated statistician, and for many years author of the Registrar-General's Returns, died in London on April 10th, aged 76.

Personal.

Robt. C. McCorkill, M.D. (McGill, '82), has left for Edinburgh.

M. O'B. Ward, M.D. (McGill, '75), left for France on the 28th ult.

H. J. Harrison, M.D. (McGill, '83), left for Edinburgh on the 12th.

G. A. Dearden, M.D. (McGill, '83), has commenced practice in St. Paul, Neb.

F. S. Muckey, M.D. (McGill, '83), sails to Paris on the 27th to continue his studies.

Arch. McLeod, B.A., M.D. (McGill, '83), is attending the Polyclinic School, N. Y.

J. J. E. Maher, M.D. (McGill, '83), has opened an office at 455, 2nd Avenue, New York.

E. J. Laurin, M.D. (McGill, '81), has moved from Virginia City to Deer Lodge, Montana.

Thomas Gray, M.D. (McGill, '79), of Brigus, Newfoundland, has gone to Europe for an extended course of study.

Dr. Arthur A. Browne left on the 7th for Europe, where he will visit the chief Lying-in Hospitals and Obstetric Clinics.

In political circles it is rumored that Dr. Orton, of Fergus, will succeed the Hon. Mr. Pope, as Minister of Agriculture.

And. Stewart, M.D. (McGill, '83), left for London on May 1st to join the Canadian contingent at the London Hospital.

H. J. Burwash, M.D., (McGill, '79), Professor of Clinical Medicine in the Northwestern University, Minneapolis, has joined the Benedicts.

W. L. Gray, M.D. (McGill, '81), of Pembroke, Ont., left for Vienna on the 10th. He purposes spending a year abroad at the chief hospitals of Europe.

R. B. Struthers, M.D. (McGill, '83), has left for Liverpool, Eng., to join the Allan S. S. Co., having received the appointment of Surgeon to one of the ships.

W. T. Duncan, M.D. (McGill, '82), and T. N. McLean, M.D. (McGill, '82), for the past year resident medical officers in the Montreal General Hospital, have gone West.

John A. MacDonald, M.D. (McGill, '80), who has been one of the resident medical officers of the Hospital for the past three years, has begun practice in the city at 1 Belmont street.

Andrew Henderson, M.D. (McGill, '80), late House Surgeon of the Montreal General Hospital, left on the 18th April for Calgarry, N.W.T., where he has taken up land and intends also to practice.

Mr. Lamirande, the collector for the C. P. & S. of Quebec Province, has moved his office to 63 St. Gabriel Street. This gentleman is a candidate for the Inspectorship of Anatomy in the Montreal District.

Dr. Bucke (McGill, '62), Supt. of the London (Ont.) Asylum, was in town for a few days last month, the guest of his old classmate, Dr. Trenholme. He has been instructed by the Ontario Government to examine Mann, the L'Orignal murderer, and give evidence as to his mental condition.

Medical Items.

—The Ontario Medical Association meets in Toronto on the 6th of June.

—The American Medical Association meets in Cleveland on the 5th, 6th and 7th of June.

—Virchow's *Archiv*, now in its 92nd volume, appears in improved paper and type.

—An old feud: The feeling between ague and quinine is exceedingly bitter.

—Cotton wool saturated with equal parts of chloral and carbolic acid, and allowed to dry, is a cure for toothache.

—A mill pond in Indiana is said to be good for three hundred cases of chills and fever a year, and furnishes two drug stores a pretty fair support.

—An old lady who lives in Massachusetts heard that Mr. John Bright was going to visit America. "Well," said she, "I hope he won't bring his disease with him."

—The attendance in the present summer session of McGill Medical Faculty is larger than in any previous year. With three exceptions, all the final students have returned.

—Talk of the days of blunderbuss prescriptions being over! The following is taken *verbatim* from a prescription recently dispensed by a Lower Province druggist from one of the most eminent local practitioners:—

℞ Pot. Bromide, Pot. Chlor., Pot. Iodid., Pot Acetas, Pot. Bi-Carb., Ammonia Chl., Ammonia Bromide, Ext. Calombo, Ext. Gentian, Ext. Taraxaci, Ferri Pyrophosphas, āā 5ij; Syrup Ferri Iodide, Tinct. Valerianas Amm., Dil. Phosphoric Acid, āā fl. oz. j; Pepsine, gr. xxx; Tinct. Cannabis Indica, Tinct. Digitalis, āā fl. oz. ss; Syrup Calcii Lacto Phosphas, Glycerine, Syrup Tolu., Tinct. Cinchona co., āā fl. oz. ij; Liq. Arsenicalis, fl. dr. ss; Tinct. Arnica, fl. dr. ss; Ext. Nux Vomica, gr. x; Ext. Conii, Ext. Belladonna, Ext. Hyoscyami, gr. vi; Chloro-

formi, gtt. x ; Quinine, 5j ; Alcoholis, q.s., fl.oz. xvi. M. Sig. Shake and take two teaspoonsfuls after each meal three times a day in a glass of milk.

Sir T. Spencer Wells.—The great honor of a baronetcy has been conferred upon Mr. Spencer Wells. This announcement will be received with the greatest approval by the profession throughout the world. The profession and the public are under an enormous debt to Sir Spencer Wells for his life-long labors in their interest, and this mark of honor from his Sovereign does something to repay it.

American Lint.—We have received a sample of surgeon's lint from Messrs. Seabury and Johnson. We understand that they have just established the first lint-works on this continent. The specimen before us is particularly good. Compared with the ordinary commercial article, its superiority is easily observed. It is beautifully white, very soft and fluffy, and tears readily in any direction. Druggists would do well to bring this manufacture under the notice of their customers.

Fehling's Test Tablets.—A specimen of these articles has been furnished us by Mr. H. R. Gray, chemist. They are from the manufactory of John Wyeth & Bro., and form the most convenient possible sugar-test one can have. Each tablet is to be dissolved in a given quantity of water, which then gives the officinal (U.S.P.) solution of Potassio-cupric Tartrate. They are said to be very reliable, and to keep well.

Iodoform and the Diapedesis of Leucocytes.—Binz (Virchow's Archiv) reports a series of experiments which go to show that iodoform has a similar effect with quinine, carbolic acid and eucalyptol, in checking the diapedesis of white blood corpuscles. He holds to the opinion that diapedesis is due to a vital property of the leucocyte and not, as Colnheim and Hering maintain, to an alteration in the wall of the vessel. He is inclined to think that it fastens itself to the vascular wall, which it digests at the point of attachment and thus makes for itself a passage. This digestion properly is due to the peptone

which is found in pus corpuscles and to the presence of which the liquefaction of pus is due. Iodoform destroys the action of this peptone, and thus prevents diapedesis, by the liberation of iodine. Its action in this regard is identical with that of iodides of potassium and sodium, the former of which is, because of this property, regarded in Germany as a successful agent in the treatment of croupous pneumonia. By thus preventing diapedesis of leucocytes it prevents the formation of pus, the corpuscles of which have their origin in the white blood-corpuscles which find their way though the parietes of the blood vessels.

REMONSTRANCE OF AN ASYLUM SUPERINTENDENT.

On the suggestion of a doctor that those who associate with the insane transmit the disorder to their offspring.

Dear Doctor, I beg you—I pray you—don't tell us
That you really believe in an insane bacillus!
That in mingling with patients we're breathing an air
Full of germs of mad phrenzy and hopeless despair;
That, although our own minds may seem perfectly sane,
Parasitical growths will forever remain
In our system, infecting the blood and the brain;
So that if, by good luck, we ourselves don't go mad,
The child will inherit the germ of its dad!

Already, in truth, are our troubles enough,
Without being told this nonsensical stuff;
In peril from blows, in peril from flurry,
In peril from fire, in peril from worry,
In peril from Lunacy Board and Committee;
Are these not sufficient, dear sir, in all pity?
Forbear then to talk, I beseech you, until I
Have time to examine these wretched bacilli.
But if you insist on such growths diabolic,
Please send me a box of mental carbolic. Y.

—The value of the CHEMICALLY PURE hypophosphites in the treatment of consumption and similar diseases has of late years been very generally recognized. Dr. McArthur of Lynn, Mass., has prepared a chemically pure syrup containing these salts, which has been used with great success, and has received the endorsement of many prominent physicians. Full particulars furnished—to *physicians only*—on application.—*Boston Journal of Chemistry.*

CANADA

MEDICAL & SURGICAL JOURNAL

JUNE, 1883.

Original Communications.

A CASE OF FATTY DIARRHŒA.

By ALGERNON WOOLVERTON, M.A., M.D., Hamilton.

(Read before the Ontario Medical Association, June 5th, 1883.)

The diversity in the character and nature of matters discharged at times per anum is, upon reflection, something remarkable. The three great kingdoms of Nature—animal, vegetable, and mineral—are, upon occasion, found represented. It is not my purpose to catalogue, even in a summary manner, all these various matters, but merely to introduce to your notice a case illustrative of the above statement, which, I trust, will prove of interest to the members of this Association, not only on account of its great rarity, but from the very nature of the case itself. It has to deal with the discharge of fatty matter in considerable quantity per rectum.

Mrs. G., aged 33, Canadian, of German parentage (both living), has been married over eight years, and during that time has borne four children, one dying aged 2 years, the others being in good health. She first came under my notice some two years ago, suffering from a large abscess under the right pectoral muscles, from which she made a slow, but good, recovery. Since that time I have occasionally treated her for minor ailments, for the most part referable to a disordered digestion, attributed by me to secret alcoholism. Though healthy and robust-looking when I first knew her, she has of late been gradually losing flesh, and acquired a bloated, puffy appearance, no doubt attributable to her habits. On various occasions, during last summer, she

casually mentioned to me that she suffered from diarrhœa, which was sometimes better and sometimes worse. Attributing it to her alcoholic habits, I warned her against her besetting sin, but to no purpose, as she denied any excess. As her appetite felt fairly good, she was able to drift along, attending to her household duties in some sort of manner.

She came to my office on the evening of October 10th, of last year, in considerable trepidation, on account of passing what she called a "yellow scum," which came away from her with a "gush of wind," just before her bowels were going to be moved, and which she stated floated like "grease" on what she passed in the chamber-pot. She also mentioned that her diarrhœa was very troublesome, as many as four or five evacuations taking place during the day, and quite as many more during the night, each evacuation being preceded by this discharge of yellow scum. As her neighbors, including the ubiquitous "old woman," had never seen or heard of the like before, and prognosticated all sorts of direful results, my patient became alarmed, and hence her visit to me. I directed her to go home and to keep what she passed during the night, and that I would call in the morning. On my arrival next day, I was shown a most noisome-smelling mixture, to even a professional nose. To sight, a yellowish greasy-looking substance, very much resembling melted bees-wax, occupied at least half of the superficial area of the fluid contents of the "whited sepulchre" which held it. I was considerably puzzled at first to know what was before me, but a slight examination only was needed to show that it was of a fatty nature. I therefore concluded that it must be a case of that rare disease, *fatty diarrhœa*. The microscope confirmed this opinion, as only fat cells were found. When first passed it was semi-fluid, but speedily became firmer and more consistent, and appeared to be in irregular-sized cakes, about a quarter of an inch in thickness, and, as was stated before, always preceded the fœcal evacuations, and was accompanied with a considerable discharge of flatus, which heralded its delivery. The quantity I saw in the pot would probably weigh between two and three ounces, and on this estimate, the total quantity passed in the 24 hours would at least reach ten or twelve ounces.

On questioning her as to the time when it first appeared in her evacuations, she was positive that it was not longer than two or three days prior to her visit to me, and as it disappeared as suddenly a few days subsequently to my visit, its total duration could not have been longer than ten or twelve days. But it is somewhat singular that in the succeeding week it again put in an appearance for two days only, and then disappeared, with no return up to the present time.

During the progress of the diarrhœa Mrs. G. lost weight rapidly, and felt very languid and debilitated, with nearly total loss of appetite; but she gained 5 lbs. in a week after its final disappearance, with a corresponding improvement in her appetite and general health. I may state that she had no great amount of pain at the time, but complained of some uneasiness and tenderness on pressure in the gastric region. The liver and spleen were not found perceptibly enlarged; and the urine was found free from albumen and sugar. I diligently questioned her as to her diet, and she stated that while at no time was she fond of fatty kinds of food, yet, during the period of the fatty discharge, she had an actual distaste and repugnance for all kinds of fat, and lived chiefly on tea and toast. If her statements be true, and I have no reason to doubt them, it would necessarily seem that the quantity of fat discharged was greater in amount than could be accounted for by the food taken. The short duration of the discharge prevented any systematic comparisons being made between the amount of fat consumed in the food and that discharged per rectum. It is unfortunate that this could not have been done, so as, if possible, to discover whether the fat discharged was simply undigested food-fat or an actual secretion at the expense of the general system. This important point has been too much neglected by most observers, and is at the present moment a subject of dispute.

It is not my intention to enter at any length into the different views held as to the sources of fat in the human economy: Whether oleaginous food is alone the source from whence the fat is derived, and which enters the system, unchanged, in the ordinary manner (this view must ignore the mechanical and physio-

logical difficulty of the passage of an insoluble substance through the cell-walls), or whether fat is derived from the disintegration of the albuminates, or, again, from the carbo-hydrates. It is most probable that fat can be derived from both of these latter foods, or from either one or the other upon necessity. As a proof of this, it has been ascertained that the honey-bee can make wax (an oleaginous substance) when fed on pure sugar alone. The view most generally held now, and probably the most correct one, is that the fat taken is converted into a soap by the action of the pancreatic juice and the alkali of the biliary acids, in which form its passage through the intestinal epithelium and fat cell-walls would be comparatively easy. Without further discussing this matter, it is more pertinent to our present purpose to consider the pathological condition which enables fat to traverse the whole length of the intestinal canal unabsorbed, and be discharged with or without the stools per anum. This can occur in only one of two ways. Either from the ingested food-fat passing undigested and, consequently, unabsorbed through the whole tract of the intestines; or, secondly, directly from the fat stored up in the system becoming reabsorbed, and then discharged into the intestines, to be discharged as before. It is not likely that both conditions would exist at one and the same time; and to discover which of these causes is existent in any particular case is sometimes more difficult than one might at first imagine. Its solution would depend upon a careful comparison of all food ingested that was capable of supplying fat with the amount of fat discharged. When this amount is found to be greater than can be accounted for by the ingested food, it would seem as if no other resource was open to us but to look to the adipose tissues of the body as the storehouse from which the fat is derived. Many observers are sceptical as to the possibility of this latter condition, and think the error arises from a want of careful comparison between the food ingested and the fat discharged, and, perhaps, from trusting too much to the exaggerated statements of the patients themselves. On the other hand, Dr. Wells, in the *New York Med. Times*, in 1854, reports a case where the patient abstained from fat and fatty foods for several weeks, without any apparent de-

crease in the amount of fat passed; and, singularly, upon a return to a fatty diet, the amount of fat discharged did not seem to increase. A similar case is also reported by Dr. Bright. It is a well known fact that in many cases where a fatty diet is indulged in, more or less fat passes by the stools, as in infants fed on milk, and the amount is proportional to the amount consumed. But this must not be confounded with the pathological condition when the amount of fat passed is excessive, and out of all reasonable proportion, as in the present case.

It would now be advisable to briefly consider the morbid conditions which produce this excretion. Kuntzmann (1820) seems to have been the first to draw attention to the connection between the presence of fat in the stools and a diseased condition of the pancreas; but it was not till Bright, in 1833, reported 7 cases of that nature that the attention of pathologists was specially directed to it, and many subsequent observers have confirmed this connection. Reeves, for example, collected reports of 16 fatal cases. In 11 of these, disease of the pancreas was found; in the other 5 cases, it was healthy. Dr. Griscom reports 24 cases, of which 14 were fatal; 8 of these were found to have diseased pancreas. No post-mortem examination was made in 14 of the cases, and consequently the condition of the pancreas could not be definitely ascertained. Jaundice was present in 6 of the cases, and diabetes in 2. On the other hand, Da Costa reports 37 cases of cancer of the pancreas, and in only 3 of these was fatty diarrhœa present. Barnard thought the pancreatic juice alone enjoyed the power of emulsifying fats, which thus prepared them for absorption from the intestinal canal. And he considered that when this secretion was modified in quantity or quality by any morbid condition, fat would necessarily be present in the stools, on account of its not having undergone the necessary emulsification which fitted it for digestion. In proof of this he made several experiments on dogs by injecting melted tallow into the pancreatic duct, when it was found that large quantities of undigested fat was passed in the stools, accompanied with rapid wasting, notwithstanding a voracious appetite. But this view is now held to be too narrow and exclusive. Frencks, Schmidt,

Lehmann and others are of opinion that the intestinal secretions, but especially the bile, share this emulsifying power with the pancreatic secretion. It has been shown by experiment that when the bile is directed from the intestinal canal, fat appears in the stools, much the same as in the case of the suppression of the pancreatic juice in Barnard's experiment. Cases have been reported of this kind where disease of the liver was alone found, the pancreas being quite healthy, fat having been present in the stools. Again, fatty diarrhœa has occurred where a post-mortem examination showed no recognizable disease of either the liver or pancreas. Such a case is reported by Prout in a woman, where the only pathological condition discovered was ulceration of the large intestine. Fatty stools have also been found in cases of phthisis, diabetes, cholera, typhoid fever, intestinal tuberculosis, and other diseases.

It would seem, then, that any morbid condition which interferes with either the digestion or absorption of fatty matters may produce fatty diarrhœa, provided a fatty diet be indulged in; and from the fact of frequent recoveries having taken place, it is probable that it may be produced by mere functional disturbance. At all events, this explanation seems best to explain the case I have had the honor of presenting to you. Its short duration, the improvement in health, and the absence at the present time of symptoms of any grave organic disease, would harmonize best with this view of the matter. Tulpius (1652) gives the report of a case where fat was not alone found in the stools, but also in the urine. And Jäger relates the finding of fatty concretions in the vagina, but one cannot help indulging in some suspicions as to the genuineness of this latter case, when the many hysterical vagaries of the sex is considered. As analogous to this subject, it might be well to mention that peculiar substance, *ambergris*, which is well known to be a fatty secretion into the intestines of the *Physeter Macrocephalus*, or sperm-whale. Enormous quantities of this is sometimes found. In one whale it amounted to as much as 182 lbs. It is thought to be due to a diseased condition of the intestines, as when found, the whale is in poor condition, being either thin or sickly, or even dead.

Formerly many ridiculous explanations were given for its presence. Some considered it to be solidified sea foam; others, a fungoid growth of the sea, similar to the fungus on trees; and others, the excreta of birds, etc. Elliotson compares the fatty matter in the diarrhœas to this ambergris, and suggests that their different consistency is due simply to their containing different proportions of elaine and stearine. Home (1813) speaks of its resemblance to adipocere, and suggested that the fat might be the product of the albuminoid matters of the food; and he also likens it to the ambergris of the whale, and suggested the bile as the chief cause of the fat metamorphosis.

The little semi-transparent masses that are sometimes seen in diarrhœal and dysenteric discharges, and which have been compared to grains of boiled sago and frog's spawn, must not be confounded with true fat. Heubner and others thought they were composed of mucus, moulded into this shape by ulceration of the follicles of the colon. But Virchow found them to be derived from the starchy articles of food, as they turn blue under the iodine test, and sarcastically says that what has been called sago-like mucus is much more frequently mucus-like sago. Heubner also speaks of these bodies as identical with the "corpora pinguia" of the ancients, but though this may have been true of some cases, it is certain that the "corpora pinguia" were in other cases really fat. Hippocrates, Philagrius, and especially Galen, have noticed and recorded cases of fat appearing in the stools, and they thought that fat was an ordinary constituent of dysenteric stools in the early stages, and this view continued to be held until the beginning of the 17th century. It is probable that the whitish muco-purulent matters of dysentery were mistaken for fat. Aretaeus describes a white, thick substance like "chopped tallow," which subsequently became known as the "corpora pinguia" as occurring in dysenteric stools. This must have been true fat. The ancient fathers of medicine considered that this fat was derived from the fat of the intestines and mesentery, which underwent liquifaction from the heat of the disease; and when fat was found in the urine, its source was supposed to be the adipose tissues in the neighborhood of the kidney.

The duration of this peculiar diarrhœa adiposa (so named by Sauvages) is very various—from a few days, as in the present case, up to six years. The prognosis, of course, depends more upon the nature of the morbid condition producing it than upon the quantity of fat discharged.

Very little is to be said about the treatment. My case recovered without any treatment. Griscom and Elliotson report cases from the administration of olive oil, which seems rather Hahnemannic ; but whether the case was *post hoc* or *propter hoc* is not very evident. Six to eight ounces of whiskey daily only was needed in another case, reported by Griscom in the New York Hospital, to stop the fatty discharge, which reappeared when the whiskey was not taken. Dr. Wells reports a singular case, where 3 gills of fat was passed daily for over two years, and which recovered in a few weeks by the patient leaving his trade as a carpenter and taking to farming.

The literature on this subject is not very extensive, most authors having very little or nothing to say upon the subject. Probably the fullest account of it is given by Dr. Woodward in the "Medical History of the War of the Rebellion," Vol. II., which was hindly sent me by my friend Dr. Osler, and from which I have procured much of the information given in this paper. I am also indebted to Dr. Osler for this specimen of fat (now presented) passed by my patient, my own supply having, unfortunately, been destroyed.

DROPSY OF THE ANTRUM—PUNCTURED AND DRAINED—CURE.

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(Read before the Medico-Chirurgical Society of Montreal.)

Richard W., aged 10, was first brought to me for advice in the beginning of October 1881, in reference to a fullness of the left cheek and prominence of the malar process on that side. He was a delicate-looking lad, belonging to a somewhat strumous family, but had enjoyed fair health up to the present. During the previous winter he had been hit by a hard snow ball on that cheek, of the effects of which he had complained for some

time; and early in the spring he had received another severe blow on the bridge of his nose, which his mother at the time thought had dislocated the nasal bones. I saw him, however, on the next day, and could not then make out any displacement.

His mother referred the present trouble to these injuries. The fullness had been first noted some six weeks previously, and had been gradually increasing since. At the time of her visit it was very evident on inspection. On examination there was found to be marked bulging of all the anterior wall of the antrum. The child was in good health otherwise. There was no difficulty in breathing through the nose, nor any sign of tumor in the pharynx or nasal cavities. I saw him at intervals during the next six weeks, during which the fullness slowly increased, but no softening of the bone was discovered. I now asked Dr. Roddick to see the case with me. He agreed with me in regarding it as due to pressure from within the antrum. On careful examination this time, now eight weeks after date of his first consulting me, limited softening and slight fluctuation could be detected on the root of the second bicuspid tooth. His health otherwise remained good. The following week fluctuation was quite evident over the roots of the canine and the two bicuspids—and crackling of the thinned bone was felt distinctly. A puncture with a scalpel was made over the root of the first bicuspid, and about ʒij of glairy colorless fluid escaped, with relief to the local tension. This again shortly accumulated, and five days afterwards the whole facial surface of the bone was pliable, crackling under pressure, and the hard palate on that side for about half an inch back from the alveolar process was bulging.

The lad was taken to the office of Mr. Alf. Wright, Dentist, who carefully removed the canine and two bicuspids on the affected side. Their fangs were almost absorbed. The alveolar process was soft and crumbling, so that care had to be taken to injure it as little as possible. With the removal of the teeth a large quantity of glairy fluid escaped from the antrum through the opening thus made into its floor. Mr. Wright afterwards made a plate supporting a small hard rubber tube about the diameter of a

goose quill, which passed into the cavity through the opening made by the first bicuspid, and kept it drained. A lotion of carbolized water was also given to the mother with directions to have the cavity syringed out frequently. With the removal of the pressure the prominence at once disappeared, reducing completely the deformity of the face. The cavity filled up, and now after the lapse of eighteen months there is no appreciable difference between the two sides.

The diagnosis in this case was somewhat difficult at first, and a more formidable tumour of fibrous or myxomatous character at first feared. The nature of the case was, however, made evident by the first puncture. The injuries the child received probably had a good deal to do with the formation of the cyst; but whether by closing up the aperture connecting the antrum with the nasal cavity, or whether by inducing some morbid change in the mucous glands, naturally existing in the lining membrane of the antrum, it is difficult to say.

After the operation Dr. Roddick, who was present and whose advice was taken throughout the case, and myself, endeavored to make out the position of this aperture in the nostril, but both of us failed.

A very similar case is quoted by Mr. Pollock in Holmes' Surgery, where the cyst occupied a large portion of the left side of the upper jaw. Its anterior wall bulged out the side of the face. A free incision was made into the cyst from within the cheek. The anterior wall was found to be partly membranous, and partly consisted of thin flakes of bone. A portion was readily removed, so that a free opening was left for the escape of the contents, which were of glutinous consistence and brownish in color. At the bottom of the cyst there was found projecting into its cavity the extreme point of the fang of the canine tooth. On its removal the fang was found partially necrosed. The cyst filled and closed in a short time without any further treatment. The patient was about ten years of age, and when he quitted the hospital there was no trace of disease nor the slightest disfigurement.

THE STUART PERIOD FROM A MEDICAL STANDPOINT.

By R. L. MACDONNELL, B.A., M.D.

[*A Paper read before the Athenæum Club, Nov.* 28, 1882.]

[Continued from page 593.]

Little has been written of the medical history of Charles I. It is probable that he was a man who enjoyed good health all his life. Mayerne was still chief physician, while amongst the medical advisers of the court were Bates and Harvey. Bates was a medical vicar of Bray; whether Roundhead or Cavalier was in power, he always found himself in favor. The medical attendant of Cromwell himself, at heart he was a Royalist. In his record of his own times, entitled "Elenchus Motuum Nuperorum in Anglia," the character of the Protector is thus protrayed: "Egregius simulandi et dissimulandi artifex, qui sublatis in cœlum oculis, dextraque pectori applicata, Dei nomen invocabit, lacrymabitur, precabitur et aget pœnitentiam donec sub quintâ costâ trajecerit alloquentem." The malice of the King's enemies, he says, pursued him even after his death. He mentions in the Elenchus, with great disgust, one Trapham who embalmed the King's body, and during the operation uttered several coarse jests and unfeeling expressions. This Trapham was surgeon-in-chief to the army of Oliver Cromwell, and though he did say that he was stitching on the head of a goose, yet he did his work well. After 165 years the features of the King were plainly recognizable, bearing a striking resemblance to his protrait in coins, busts and paintings. The fourth cervical vertebra was found smoothly divided transversely.

Successive generations of Harveian orators at the Royal College of Physicians of London, have left little to be said about Harvey. I wish merely to attempt to do away with the prevalent notion that Harvey was a loser by his discovery, contemporary writers, Aubrey for instance, saying that his practice fell off. It must be remembered that the laborious research which led to his glorious discovery left little time for the cultivation of private practice. Still more unjust

is it to say that his professional brethren threw obstacles in his way and ridiculed his theories. Nothing beyond healthy criticism was called forth by his lectures on this subject, and the publication of his great treatise, " de motu sanguinis."

Harvey's family were distinguished in commerce, his brothers being wealthy merchants in the Eastern trade. At the age of nineteen he took his B.A., in 1597, at Cambridge. After a long course of study abroad he became a Fellow of the College of Physicians in 1607, and in the following year, by the recommendation of the King, the President of the College of Physicians, and several of its senior fellows, was appointed physician to St. Bartholomew's Hospital. After nine years spent in study and experiment, the treatise was published. Harvey was always high in favor at court. In 1615 he was physician extraordinary to James I. In 1629 he was appointed by the King travelling physician to Lord Lennox. In the annals of the College of Physicians it is related how when Harvey gave up the Treasureship he called the Fellows together, and " post splendidum convivium " publicly resigned office.

Harvey was in attendance upon Charles I. at the battle of Edgehill in 1642. In 1645 he was by Royal favor made Warden of Merton College, Oxford. He died in affluent circumstances in 1652. The College of Physicians during his lifetime erected a statue of him in their hall.

Aubrey, a contemporary, describes Harvey as being " not tall, but of the lowest stature ; round faced, olivaster (like wainscot) complexion, little eye—round, very black, full of spirit—his hair black as a raven, but quite white twenty years before he died."

Charles I., with all his faults, is greatly to be commended for the encouragement he gave to all arts and sciences, and for the personal interest he took in them. Harvey's experiments interested him greatly, and the fashionables of 1642, instead of, as in 1882, throwing obstacles in the way of advancing science, not only witnessed dissections of living animals, but actually furnished the subjects for them. Aiken tells us that the interest his Majesty took in Harvey's researches were of singular

service to him in his investigations concerning the nature of generation, as the King's favorite diversion of stag hunting furnished him with an opportunity of dissecting a vast number of animals of that species in a pregnant state.

Oliver Cromwell, in his younger days, when he lived in Huntingdonshire, was a hypochondriac. His physical sufferings had much to do with his gloomy ideas of religion. At his country seat he frequently fancied that his death was at hand. It is on record that Dr. Simcott, of Huntingdonshire, was constantly being sent for, and no doubt that worthy practitioner went with a grumble to minister to the woes of the *malade imaginaire.*

At this time Oliver was constantly consulting Dr. Mayerne in London. The court physician undoubtedly must have given him twenty grains of calomel, his favorite dose, although no mention is made of treatment in the Ephemerides. "Monsieur Cromwell valde melancholicus." The records go on to state that the Great Oliver was the victim of a periodic pain in his stomach, whose time of attack was exactly three hours after the future Protector had eaten his dinner. Its favorite site was in his left side. Probably it was an enlarged spleen, the result of malaria. Cromwell had just returned from drinking the waters at Wellingborough, in the county of Northampton. The consultation took place on the 29th September, 1628. This long residence in Huntingdonshire, a tract of country notoriously ill-drained, was probably the origin of the ague from which he suffered during the rest of his life.

During the Scotch campaign he was constantly upon the sick list; and the Parliament were so concerned that they sent Dr. Bates and Dr. Wright to Scotland to advise him, as well as to report to Parliament his condition of health. He refused to follow the advice offered him—that he should retire from active life.

For the next seven years after this, Oliver Cromwell enjoyed good health. He was made Lord Protector in 1653. The year 1658 was one of trouble and anxiety. He lost by death his friend, the Earl of Warwick, his son-in-law, Mr. Rich,

and, worst of all, his favorite daughter, Mrs. Claypole. Her last illness was prolonged and painful. She died, it was thought, of cancer. For fourteen days and nights Cromwell was a constant attendant at her bedside.* It was said that his refusal of the request that the life of Dr. Hewett should be spared, weighed so heavily on the mind of the dying woman that her last words were those of bitter reproach. This Dr. Hewett, who was executed for high treason, was the divine who had officiated at the marriage of Mary, his third daughter, to Lord Fauconberg. All these melancholy causes are said to have so affected him in body as well as in mind as to be considered at the time sufficient cause for the return of his ague. An attack of gout still further reduced him, and his haggard appearance became an occasion of alarm to those who knew him well. Fox,† the Quaker, met him riding in Hampton Court Park, and says: "I saw and felt a waft of death go forth against him; and when I came to him he looked like a dead man."

The physicians of Cromwell were Harvey, Bates, Maidstone and Worth. At this time intermittent fever set in, and the heart, perhaps fattily degenerated, showed early signs of giving out. Dr. Bates tells us that although all were anxious about him, he had sufficient strength to walk about and attend his duties. "But one day," says Bates, "after dinner, his five (I know of but four) physicians coming to wait upon him and having felt his pulse, said it intermitted; at which, being suddenly startled, he looked pale, fell into a cold sweat, almost fainted away, and ordered himself to be carried to bed, where, being refreshed with cordials, he made his will." Strangely enough, in his last illness he was possessed with a firm belief in his recovery. Observing the anxious countenances of the physicians, he is reported to have said: "Ye physicians think I shall die. Don't think I am mad; I speak the word of truth upon surer grounds than Galen or your Hippocrates furnish you with; God Almighty himself hath given that answer, not to my

* An account of the last hours of the late renowned Oliver Cromwell. London, 1659.

† *Fox Journal*, Vol. I, p. 485-6. Quoted by Mr. Cooper.

prayers alone, but also to the prayers of those who entertain a stricter commerce and greater intimacy with him. * * * Ye may have skill in the nature of things, yet Nature can do more than all physicians put together, and God is far above Nature." This account is taken from the "Elenchus" of Dr. Bates, which is scarcely a reliable authority. Death-bed speeches are in the majority of cases imaginary. That night "the chaplains and all who were dear to God," Dr. Bates goes on to say, "being dispersed into several parts of the palace, have prayed to God for his health, and have all brought this answer, 'he shall recover.'" Clarendon tells the same story. "But the fits grew stronger and his spirits much abated; so that he returned again to Whitehall when his physicians began to think him in danger, though the preachers, who prayed always about him and told God Almighty what great things he had done for him, and how much more need he had still of his service, declared as from God, that he should recover."

Cromwell died at Whitehall on the afternoon of Tuesday, September 3rd, 1658, that day being the anniversary both of Dunbar and Worcester. He was the last Englishman of note to die in England of ague. Cinchona bark came into use in England about 1655. Had it been administered judiciously, Cromwell's life would have been saved. Unfortunately, a wretched City Alderman, one Underwood, died whilst taking the bark, which gave rise to so much idle talk about the dangers of the new remedy that the physicians feared to employ it.

Abundant contemporary evidence exists as to the prevalence of ague in England to account for the deaths of two men of note such as James I. and Cromwell. At that time the soil about London was neither drained nor cultivated during some months of the year. The marshes of Cambridgeshire and Lincolnshire were covered with clouds of cranes.* Southwark was a swamp, and at Westminster there is a gate called the Marshgate,† from being situated in a place where there was once a marsh. Ague was less prevalent after the Great Fire. The number of deaths decreased per annum rapidly. In 1728

* Macauley. † Ellotson.

there were 44; and in 1730 only 16. In the ten years from 1800 to 1810 four deaths were registered. Dr. Caius says that ague was so fatal in London in 1558 that the living could hardly bury the dead. Burnet says it raged like a plague. According to Sydenham, from 1661 to 1665 it was the most fatal disease in England. In the Walcheren expedition, 10,000 men, two-thirds of our force died of marsh fever.

The body of Cromwell was got rid of in some mysterious manner immediately after the autopsy was over. A wax figure in a suit of velvet, richly laced with gold and trimmed in ermine, lay in state in Somerset House in a room hung with black velvet, until 23rd November, when it was buried in the Abbey. The ceremony cost £6,000. In 1660 the Lords and Commons thought that they might then with safety kick the dead lion. An order was passed "that the carcases of Oliver Cromwell, Henry Ireton, John Bradshaw and Thomas Pride, whether buried in Westminster Abbey or elsewhere, be with all expedition taken up and drawn upon a hurdle to Tyburne and there hanged up in their coffins for some time; and after that buried under the said gallows." In a pamphlet in the Harleian Miscellany it is recorded that a certain clergyman whose name is not given, made a sworn statement shortly after this desecration of Cromwell's remains that Roundheads in disguise had taken that of Charles I. from its resting place, and substituted it for that of Cromwell. Although a dead body of an unknown person took the place, yet it was highly improbable that it was that of the King, for, as has been mentioned, the royal corpse was found intact in the beginning of this century in its coffin.

The last resting place of the Protector is still undiscovered. According to contemporary report it was wrapped in lead and dropped into the Thames. A more circumstantial account is to the effect that in compliance with his dying request, the body was buried in the battlefield at Naseby. Cromwell's family foresaw that his power would die with him, and rightly judging that the return to power of the Royalists would be certain to be followed by the desecration of the remains, took measures to hide the corpse. Early decomposition was very improbable,

but it is likely that this statement was made by the physicians in order that his friends might have an opportunity of getting the body out of sight. Recently a writer in the *London World* stated that the body of Cromwell rests in Newburgh, in Yorkshire, on the estate of Sir George Wombwell. It was said to have been taken there by Cromwell's daughter, Lady Fauconberg, whose grand-daughter married an ancestor of Sir George. This tomb has never been opened.

When the second Charles became King, the court physicians all retained their places, Harvey, Mayerne, Bates and Sir Charles Scarborough; Prijean and Hamey were amongst them. The new additions to the list made by the King were of a sort such as one would suppose the dissolute monarch would have about him, viz.: Archer, Whistler, and the notorious Toby Whittaker and Fraizer. Charles Scarborough, a man of great repute as an anatomist, was the friend and associate of Harvey in his investigations. He was physician to Charles II., James II. and William III., and had the honor of being the adviser of the Duchess of Portsmouth. It seems from his writings that most of the illness of that illustrious beauty were caused by her gluttony. "Madam," Sir Charles Scarborough is reported to have said, "I will deal with you as a physician should do; you must eat less, use more exercise, take physic, or be sick."

In addition to his anatomical lectures in London, he taught mathematics at Cambridge. His epitaph records that he was

Inter Medicos Hippocrates,
Inter Mathematicos Euclides.

Scarborough was a staunch Royalist, and suffered for it. His library was destroyed in the early part of the war, and at a later date he lost his fellowship at Cambridge. He was in exile with Charles II, and returned with him on board the "Naseby." On the 24th May Mr. Pepys, who had been obliged to give up his cabin to make way for the illustrious company on board, entertained in his new quarters, the carpenter's cabin, a party of persons of lesser importance in the royal suite—the two chaplains and the three doctors (Scar-

borough, Quartermaine and Clerk). "At supper the three doctors of physique again at my cabin; where I put Dr. Scarborough in mind of what I had heard him say that children, in every day's experience, look several ways with both their eyes till custom teaches them otherwise." Evelyn was greatly impressed with Scarborough's library, and thought it contained the best collection of mathematical works in Europe. Dr. Clerk was also an anatomist. As it became the fashion in the early days of the Royal Society to take interest in scientific matter, the King devoting his leisure to chemical experiments, so the anatomists came into favor for a time. Pepys tells us that the King witnessed (14th May, 1663) the dissection of three human bodies by Dr. Clarke and Mr. Pierce, the surgeon, with which he was highly pleased.

Of the medical friends of Charles II., Hamey was certainly the most respectable. A fellow of the R.C.P. in 1634, he commenced the uphill drudgery of practice with the mill stone of poverty about his neck. He was a faithful churchman, and a devoted Royalist. The downfall of Charles I caused a great falling off in his practice, indeed to such want was he reduced that he was on the point of quitting London, when a fortunate event occurred which not only relieved present necessities, but which put him at once into affluent circumstances, enabling him to send Charles II sums of money he had obtained by the spoiling of the Egyptians. Mr. Palmer, a kinsman, in his biography of Dr. Hamey, tells the story:

Things had been going the wrong way with Hamey for some time. Most of his cavalier patients were in exile, and those at home had no fees to give him. Anxiety had brought on illness which prevented him entirely from earning his daily bread. There was not a penny in the house. The very first time he dined in his parlor afterwards, a certain great man in high station came to consult him "ratione vagi sui amoris," says Dr. Hamey, and "he was one of the godly ones, too, of those times." In fact it was no other than the pious Ireton.

"After the doctor had received him in his study, and modestly attended to his long religious preface, with which he

introduced his ignominious circumstances, and Dr. Hamey had assured him of his fidelity, and given him hopes of success in his affair, the generous soldier drew out of his pocket a bag of gold, and offered it all in a lump to his physician. Dr. Hamey, surprised at so extraordinary a fee, modestly declined the acceptance of it, upon which the great man dipping his hand into the bag, grasped up as much of his coin as his fist could hold and generously put it into the doctor's pocket, and so took his leave."*

"The recovery of this patient brought many more of the same cast, so that the committees for public levies were seldom without one or other of them, who always when Dr. Hamey appeared upon their summons thither, feigned some near relative or friend's extreme illness, for which he was immediately dismissed with contentment, as the lawyers say."

Hamey, though, became sly as the Commonwealth grew stronger, "he thought it sometimes necessary to move with the stream and went to hear what he hated—a barber perhaps or a cobbler hold forth; but always took care that his servant should carry for him an Aldus edition of Virgil upon vellum, in binding and bulk resembling an octavo Bible, to entertain himself with; or a duodecimo edition of Aristophanes canonically bound in red turkey leather, with clasps, resembling a Greek testament." Hamey remitted to Charles II. several sums of money, of which the receipts signed by the royal hand are in existence. On the Restoration he returned to the King a valuable relic of Charles I., a diamond ring, which had been plundered from the royal martyr, and for which the giver had to pay £500.

Drs. Archer, Whittaker, Whistler and Fraizer were a bad lot, and well suited to the court they served. Archer encouraged the King in the pursuit of his sensual pleasures. His essay upon the advantages to be derived from intemperate drinking was entitled "The possibility of maintaining life from infancy to old age without sickness by the use of wine." Whistler was a chatty fellow and told a story well. Pepys

* The Gold-Headed Cane.

describes the conversation at a quiet little dinner on 21st November, 1667.

"With Creed to a tavern where Dean Wilkins and others, and good discourse; among the rest, of a man that is a little frantic, that hath been a kind of minister, Dr. Wilkins saying that he hath read for him in his church, that is poor and debauched man, that the College have hired for 20s to have some of the blood of a sheep let into his body; and it is to be done on Saturday next. They propose to let in about 12 ounces; which they compete is what will be let in in a minute's time by a watch. On this occasion Dr. Whistler told a pretty story related by Muffett, a good author, of Dr. Caius, that built Caius College; that being very old, and living only at that time upon woman's milk, he while he fed upon the milk of an angry, fretful woman, became so himself; and then being advised to take it of a good-natured, patient woman, he did become so beyond the common temper of his age. Their discourse was very fine; and if I should be put out of my office, I do take great content in the liberty I shall be at of frequenting these gentlemen's company."

John Evelyn was constantly meeting Whistler at little dinners and cosy little suppers. In February, 1676, he supped with Sir John Williamson, "where were our (the Royal) Society—Mr. Robert Boyle, Sir Christopher Wren, Sir William Petty, Dr. Holden, sub-Dean of His Majesty's chapel, Sir James Shaen, Dr. Whistler (then President of the College of Physicians), and our Secretary, Mr. Oldenburg. The same people met at Sir Joseph Williamson's in 1683. We are told what they talked about. "The conversation was philosophical and cheerful on divers considerable questions proposed; as of the hereditary succession of the Roman Emperors; the Pica mentioned in the preface of our Common Prayer, which signifies only the Greek Kalendarium. These were mixed with lighter subjects." After a dinner at the College of Physicians Evelyn speaks of Whistler as being the "most facetious man in nature."

Charles II. died of apoplexy after an illness of but four days. The history of his case written by Sir Charles Scarborough is

deposited in the Library of the Society of Antiquaries. I obtain my information from the essays of Sir Henry Halford.* At 8 A.M. the King lost speech and motion. He was engaged at the time in making chemical experiments. Sir Edmund King, surgeon employed in the army, who was giving the King instructions in the laboratory, ran to his assistance and promptly bled him to the extent of sixteen ounces. King, for his presence of mind, was awarded a vote of thanks from Parliament, and a gift of £1,000. He got the thanks, but never the money. The court physicians to the number of fourteen then arrived. They approved of what had been done, and ordered further venesection to the extent of eight additional ounces. An antimonial emetic, a powerful purgative, and several clysters were administered. A blister to the head was applied. The King did not rally, but remained until death in a lethargic dreamy condition. The loss of the power of co-ordinating words added to the misery of his condition. Conflicting ecclesiastics struggled for an audience at each glimmer of consciousness. He probably said "yes, yes," or "no, no," to all interrogations indifferently, agreeing with the last speaker, not knowing the meaning of the words he uttered.

Macauley's version of the story of the King's death can scarcely be correct. It is unlikely that a person in the King's state, with the brain compressed as it was found to be, would be sitting up in bed exchanging polite speeches with the courtiers, and apologizing for the unconscionable time he took in dying.

Sir Henry Halford, writing in 1833, thought the treatment did not differ from that of his day, save that for the spiritus cranii humani, twenty-five drops of which were ordered in a cordial julep when His Majesty was sinking, might have been substituted a less disgusting and more effectual preparation of ammonia. Sir Henry Halford thought that the King was not sufficiently bled.

Many of the more prominent physicians of the 17th century

* Essays and Orations, read and delivered by Sir Henry Halford. London, 1842.

I have avoided mentioning. Of Harvey little is said. His life and works would afford material for a very lengthy paper. Sydenham's name is but once mentioned. An account of the times of the court physicians of William and Mary, the famous Mead, the eccentric Ratcliffe, and others, might form a pleasing subject of another paper; but already has this essay exceeded the customary limits, and so I must abruptly bring it to a close.

QUARTERLY RETROSPECT OF SURGERY.

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Antiseptic Surgery.—Dr. Robt. F. Weir, in the *Medical News* (Philadelphia), May 5th 1883, has an interesting article on "*The weak points of Listerism and the advantages of corrosive sublimate as an antiseptic.*" He remarks that it must be admitted that the dressings of Lister applied with the strictest attention to details, not infrequently fail in controlling the progress of putrefaction. This is due sometimes no doubt to imperfect construction of the dressings or the carbolic acid solution. Delacroix says ten per cent. of carbolic acid is required to destroy bacteric life, and Koch records that anthrax spores were destroyed by a five per cent. of carbolic acid only after two days immersion. But spores are much more difficult to affect than the bacilli themselves and the anthrax spore is the most resistant to disinfectants of all such micro-organisms. Koch formulates the statement that carbolic acid in one to five per cent. watery solution is a good disinfectant for those organisms which have not passed into the condition of spore growth, and that one part in 400 of water must be *permanently* present to control life in bacteria found in wounds. Dr. Weir has found that the strength of carbolic acid dressings (gauze) varied much with its age. After three months (kept in rubber cloth in a tight box) 1.44 per cent. of carbolic acid was present, although at time of preparation it contained 2.61 per cent. The gauze sold in shops contains about one-half per cent. of carbolic acid. The gauze when used

therefore should be freshly prepared. Another source of failure is encountered in the cat-gut ligature. Kocher, of Berne, gives a case where septicæmia was apparently caused by cat-gut; and Volkmann reports two cases of malignant pustule from inoculation by anthracized cat-gut. Koch has found that solutions of carbolic acid in oil or alcohol are absolutely inert in respect to their action on bacteric life, either on the spores or bacilli. He however remarks that "when it (carbolic oil) comes in contact with substances containing water, as for instance the tissues of the body, wounds, etc., then it undoubtedly gives off part of the acid to these, and in this way an antiseptic effect may be obtained."

Dr. Weir first used *corrosive sublimate* as an antiseptic in 1882, after reading an excerpt from an article of Delacroix. He used it in the strength of 1 to 2,000 for three compound fractures of the thigh and six of the leg with very satisfactory results; but the solution used was found too weak and a stronger one was employed, as Kümmel and Schede of Hamburg showed that it was free from risk of toxic effects. In 212 extensive wounds in which it was used by Esmarch and Neuber, there was no poisoning and only 3 deaths. In this number were 30 major operations, 32 re-sections, 5 herniotomies, 14 nerve stretchings, and in only 11 cases was the dressing changed more than once. Dr. Weir has himself used this dressing in fourteen major operations, and three compound fractures with the best results. One case of extensive laceration of the thigh died in twelve days of septicæmia.

The following is the mode of employment of this dressing. [Neuber, Kümmel and Bergmann use carbolic acid for the spray and instruments, and sometimes for washing out the wound]. The sponges and compresses are wet with a solution of sublimate, 8 grs. to the Oj (Solution No. 1). Silk, if used for sutures, etc., is dipped for two hours in an 80 gr. to Oj solution, and then permanently kept in an 80 gr. solution. Cat-gut as used by Kümmel is made by immersing it in an 80 gr. to Oj solution for twelve hours, and then it is wound on bobbins and kept in an alcoholic solution of twenty grains to

the pint, with one and a half ounces of glycerine added. This cat-gut, Dr. Weir finds, dissolves too quickly in the wound, and instead of keeping it in an alcoholic solution, he dips the gut for two hours in a solution 1 to 1,000 of chromic acid, and then dries it and keeps it thus. The gauze is prepared by immersing it in a solution of 20 grs. to the pint of alcohol with ʒss of glycerine added. Drainage is accomplished by rubber tubes or by spun glass twisted or plaited. As absorbents, sand, saw-dust or dried peat are used after rendering them antiseptic by adding to a pound ʒi of sublimate dissolved in ʒiss of sulphuric ether. According to Koch, corrosive sublimate is the most powerful antiseptic known, 1 part in 1,000 destroyed the most resistant mico-organism. According to Sternberg 1 part in 20,000 of mercuric chloride equals 1 part in 100 of carbolic acid.

Th. Kocher (*Sammelung Klinikische Vorträge*, No. 244, 1881) has lately been using *Bismuth* as a dressing. It is not poisonious or irritating, and is quite as antiseptic as iodoform or carbolic acid, besides by using bismuth it is unnecessary to drain, and the wound can be closed up immediately and unites by first intention. The method of procedure is as follows: The wound is, during and after the operation, washed with a mixture of bismuth and water, 1 part in 100, well shaken. The bleeding having been completely arrested, the wound is stuffed with a 10 per cent. bismuth gauze before the stitches close the wound. This gauze is removed after 12–36 hours, and the wound closed by stitches. No drainage is used. The wound is then dressed with a 10 per cent bismuth gauze and covered with gum paper and cotton wool, and this is kept in place by a gum bandage, and strips of strong plaster are used to ensure even pressure. The instruments, hands and sponges during the operation are disinfected with carbolic acid, or, in already suppurating wounds, chloride of zinc.—(*Fortschritte der Medicin*, Feb. 1883.) At the recent Congress of the German Surgical Society held in Berlin in April last, Dr. Riedel of Aix la Chapelle read a paper on the use of bismuth as an antiseptic. He advocated the use of primary sutures

instead of secondary ones as recommended by Kocher, and said also that bismuth was useful not only in fresh wounds but also in those that were suppurating. His conclusion from an extensive use of bismuth was that it was a good antiseptic, but that like all others was not an unfailing one. He had combined bismuth with corrosive sublimate with good results. In the discussion which followed Prof. Kocher remarked that his increased experience had increased his confidence in bismuth. Prof. von Langenbeck also spoke in high praise of bismuth as a remedy most useful in promoting the union of wounds by first intention. His method was to wash the wound with bismuth suspended in water, and after closing the wound carefully and inserting a drainage tube, to apply pads of bismuth, and then carefully to bandage. Dr. Israel related a case of excision of the breast treated with bismuth, in which a severe stomatitis resulted, but no other surgeon present had had a similar experience.

Dr. John Duncan (*Ed. Med. Jour.* March 1883) in an article on "*Germs and the Spray*," states that a few years ago he made an attempt to discover the percentage which remained aseptic of cases in which major operations had been performed when the skin was previously sound, and was astonished to find that in more than half the cases, most of which he had hitherto regarded as aseptic, organisms could at one time or other be discovered. He is confident this result was not due to any error of manipulation. He asks whence do these organisms come, from within or without. That organisms of various kinds easily find their way into the blood by other channels than by palpable wounds may be held as certain, and that when present in the blood they are liable to attack tissues devitalized by injury. Dr. Duncan has found that in most acute abcesses organisms exist, and he has found them in strumous and chronic abscesses. Dr. Ogston found also that in a long series of acute abscesses examined by him, chains or groups of micrococci were invariably present. The author then says that it is impossible to avoid the conclusion that if the abscess be the effect of the presence of organisms, their entrance into the blood is com-

paratively common, and that sometimes they present themselves by this means in surgical injuries, and that the severity of the resultant effects will be determined by the same causes as influence them under other circumstances. Moisture and warmth, says Dr. Duncan, favor the multiplication of these organisms, and dryness and drainage are inimical to them. Under antiseptic dressings they are less harmful than otherwise. Healthy structures may destroy a certain quantity of microbia. After relating some cases of excision which healed in three weeks, in which, though apparently aseptic, the discharge contained abundant rod-like bacteria, Dr. Duncan states that it must also be admitted that contamination comes from without, and inquires if we can by our present mode of antiseptic dressing insure exclusion of external septic influences. He goes on to relate a great number of experiments with fluids in flasks from which he draws the following conclusions: (1.) That ordinary carbolized gauze maintains a wound aseptic not because it contains an antiseptic, but because of the filtering material of which it is composed, and in which respect it is much excelled by dry cotton wool and other dressings. (2.) That so far as the destruction of floating germs in the air is concerned, the spray is perfectly ineffectual. It may be a convenient method of throwing a solution of carbolic acid on the wound, but it can be of little value in operations which deal with deep cavities. (He exposed thirty-eight flasks under the spray, and seven became putrescent; thirty-seven exposed without the spray, nine became putrescent. Again, seven flasks $2\frac{3}{4}$ inches in diameter were exposed for the same periods with and without the spray, on both sides two remained clear and five became cloudy.) Dr. Duncan holds that the risk of contamination from the air has been greatly exaggerated. His conclusion is "that in the matter of wounds our prime object ought to be the attainment of the most absolute purity in all substances brought into actual contact with them, while rare contamination which may come through the air is guarded against by washing with antiseptic solutions, or by giving the germicide powers of living textures a fair opportunity of coming into play." Dr. Duncan's experi-

ments are most valuable in assisting to clear away the clouds of uncertainty which still envelop the spray. Lawson Tait and Keith have been most successful without it in abdominal operations, and if in these why not in others.

Preliminary Tracheotomy.—In a paper on the above subject read before the New York Surgical Society (*Annals of Anatomy and Surgery*, April 1883) Dr. Chas. McBurney says the objects are several. Firstly, to prevent the passage of blood down the trachea. Secondly, to facilitate the continuous and safe administration of the anæsthetic. Thirdly, to avoid the possibility of being called upon in the course of the operation to open the wind-pipe under forced adverse circumstances. Fourthly, to permit of a continuous, rapid and complete operative procedure, and thus avoid much unnecessary loss of blood. Fifthly, to secure to the patient after the operation an abundant supply of air, which is not contaminated by the discharge from the seat of operation. It does not appear from the article that Dr. McBurney had ever himself performed a preliminary tracheotomy; he evidently comes to the above conclusions on theoretical grounds and from the experience of others. In the discussion which followed most of the speakers were opposed to the operation as being unnecessary and often dangerous, though some advocated it not very strongly. Dr. Wm. T. Bull had performed preliminary tracheotomy four times with the ordinary tracheotomy tube, Tredenlenburg's tube he saw no advantage in.

Pharyngeal Tubes.—Dr. L. A. Stimson, at the meeting of the New York Surgical Society, held Jan. 23rd 1883, (*New York Med. Jour.*, April 7th, 1883) said that since the last meeting of the Society at which Dr. McBurney read a paper on tracheotomy as a preliminary operation, he had had a patient under his care with a tumour of the superior maxilla, and it had occurred to him that possibly a substitute could be devised for the tracheotomy tube, consisting of a tube to be introduced through the mouth into the pharnyx, the space around it to be blocked with sponges in a manner that would prevent the passage of blood into the pharynx, air passages, or

œsophagus. He, with Dr. Burney's assistance, had constructed an apparatus which consisted of a tube six or seven inches in length, and of the diameter of a No. 38 urethral sound. About an inch and a half of its extremity curved to almost a quarter of a circle, and provided with a flange one-eighth of an inch in breadth, perforated with small openings through which threads could be passed. About that curved portion be tied a sponge, stitching it fast to the flange and placing behind it a piece of impervious tissue, in order to favor the retention of such blood as might soak through the sponge. After complete anæsthesia had been produced in the usual way, the tube was passed into the mouth and carried well behind the root of the tongue ; but it caused so much gagging that it was necessary to withdraw it until it reached only a little behind the uvula. Anæsthesia was maintained without difficulty through the tube. Sponges were packed around it, and as soon as they were filled with blood they were changed. The suggestion he thought so simple that he was sure it must have been acted on by others. The instrument was shown to the Society in the hopes that further trials might be made with it, which would increase its efficiency.

Removal of the Tongue by Scissors.—In the *Lancet* of April 21st 1883, Mr. W. H. N. Jacobson discusses the various methods of removal of the tongue, and comes to the conclusion that any surgeon who having made use of other methods of removing the tongue, shall be led to try Mr. Whitehead's operation (described in the *Retrospect* of Sept. 1882) will give it a decided preference ; as being equally safe, while it is far simpler and more speedy than any other. Mr. Fred. Treves in the same number of the *Lancet* reports four cases of excision of the entire tongue by scissors, by what is known as Billroth's operation, the lingual arteries having been previously ligatured in the neck, and comes to these conclusions: (1.) That it is comparatively simple and requires no elaborate apparatus. (2.) By its means more of the tongue can probably be excised than can be removed by the ecraseur. (3.) It is a practically bloodless operation. (4.) The wound that is left is an extremely simple one, and is actually a clear incised wound. (5.) The

intra-oral part of the operation requires but a short time, the actual excision occupying only about two minutes. (6.) Through the incision made in the neck for tying the lingual arteries, the surgeon is enabled to remove enlarged glands, and to detect such bodies when not able to be felt through the skin. Each lingual is reached by a curved incision that commences behind at a point some little way below the jaw opposite the anterior edge of the masseter, and that is continued down to the level of the hyoid bone, and finally carried up to the point behind and below the symphysis menti. Care should be taken not to disturb the sub-maxillary gland more than possible.

Local Origin of Malignant Growths.—In a most able address on the above subject delivered before the last meeting of the British Medical Association, and published in the *British Medical Journal* of March 24th 1883, Mr. Jonathan Hutchinson again strongly urged that cancer, in the main, is a disease local in its beginning, and insisted on the paramount importance of this doctrine as the only basis for surgical treatment. He also stated his belief that cancer by no means occupies a position of such absolute isolation as has been supposed, and that, when not the result of inheritance, it is not only sometimes, but almost invariably preceded by conditions of cell change, which are identical with those of chronic inflammation, and that inflammatory processes may pass by almost insensible gradations into those of malignancy. For this he proposes the name *Precancerous Stage*. He further suggested that there are cases in which the changes never advance beyond this introductory condition, and the malady remains ill characterized to the last. It is his conviction which grows with each year's experience, that in the rules of practice which would spring out of the full and hearty adoption of the doctrine of the local origin of cancer, rests our only hope of being able to save those who consult us from the horrors of this dreadful malady. He is sure that he has repeatedly seen syphilitic ulceration with inflammatory hypertrophy glide into cancer so imperceptibly and gradually, that he could not tell where one ended and the other began, and his impression is strong that parts formerly

affected by syphilitic inflammation posess a special degree of proneness to take on malignancy. He remarked that the causes of cancer, as we meet with it in practice, may perhaps be usefully classed as three. (1.) Senility of tissue. (2.) Local irritation, and (3) Inheritance. Of these only the two first can rank as true causes; the latter although practically of great importance, is only a mode of perpetuation of that which the other two have originated. Senility gives proclivity, local irritation excites, and subsequenity hereditary transmission may perpetuate. He instanced chimney sweep's cancer as giving the best illustration of what he meant.

With regard to its connection with inflammation, Mr. Hutchinson remarked that the infection of glands, of the viscera, and of the organism generally, is a power which cancer shares with inflammatory processes. The more we investigate, the more we shall see that all inflammations are really infective. If we could find, he goes on to say, some remedy the internal administration of which should cause a malignant ulcer to heal, or a malignant growth to melt away, as we witness when mercury or iodide of potassium is given for syphilitic formations, we should cease to notice any clearly marked clinical distinction between cancer and inflammation. And further on he states that his wish has been that our minds should be brought to that point of view in which we may see that it is, after all, just possible that what we call cancer, is only a modification of the inflammatory process; or, at any rate, to put the proposition in a more restricted form, that it is almost always preceded and initiated by changes which are of that character. He looks upon certain rare and exceptional forms of chronic ulceration (as for example rodent ulcer) which histologists will not admit as cancer, but which run a chronically malignant course, as forms of morbid action, which stand half-way between common inflammation and true cancer. Mr. Hutchinson also remarks that an ingenious argument in support of the doctrine of the constitutional origin of cancer has been based upon the fact that it almost constantly recurs after removal. But before any weight can be allowed to this contention, we must enquire where it recurs. If the

recurrence be in the lymphatic glands, or in other parts in close proximity to the growth, it proves only that excision was delayed too long, and that infection has already been accomplished, and the speaker quaintly proceeds to say that a farmer who allowed a thistle to seed before it was cut down would have no right to infer from next year's crop that his field had a constitutional tendency to the production of thistles. Mr. Hutchinson concludes his admirable and practical address with the remark that "When the doctrine of the pre-cancerous stage shall be widely adopted, and when surgeons generally shall recognize the propriety—let me say the duty—of operation for purposes of prevention, then, and I believe not till then, shall we witness a considerable reduction in the mortality of cancer."

In the discussion which followed the reading of the address, Sir James Paget, while admitting the existence of a pre-cancerous stage, the importance of which Mr. Hutchinson had urged, said it was impossible to exclude the general or constitutional influence, without which local influence would not operate to promote the disease. Dr. Thin remarked on the absence of all positive knowledge regarding the changes by which a physiologically healthy epithetial cell acquired the properties of stimulating an abnormal increase in the number of cells present in a part. Cancer cells differed in their vital properties, and in their chemical constitution, from healthy epithelial cells. Their contact was not tolerated by the adjacent vascular tissues, on which they acted like an irritating foreign body, and the action of staining re-agents showed that they differed chemically from normal. He was unable to follow Mr. Hutchinson in regarding rodent ulcer as representing a transition between inflammatory conditions and cancerous changes, the specific cancerous changes were as highly developed in rodent ulcer as in any other form of cancer.

Mr. Butlin said we were now aware of preceding conditions to tumors of two different kinds, those which were merely interesting and those which were valuable. To the first belonged traumatism, deep seated inflammations and inheritance; to the second class belonged certain typical morbid conditions, some

of which were hypertrophic, as moles, warts, etc., some inflammatory as certain chronic inflammatory conditions of the tongue, and of the vessels and areola of the breast.

Dr. Coupland suggested that the fact of long delay in recurrence of cancer might be explained by assuming that the organ secondarily infected might be the seat of cancer in the latent state.

Mr. Hutchinson in reply agreed entirely with Sir James Paget in assigning great influence to inherited tendency, but as he had urged in his paper, such a tendency must have been acquired in the first instance. In reply to Dr. Thin, that cancer and rodent ulcer were identical in the late and well characterized stages, he admitted; but there was a period in which he believed it was quite impossible to recognize it as cancer, and this assertion was to be applied also to early stages of malignant disease of the lip, tongue, penis and other parts. In all of these it was, he feared, true that the microscope, for the most part, became of use just when to the experienced eye it became unnecessary.

Treatment of Gunshot Wounds.—Dr. Roswell Park, (*Annals of Anatomy and Surgery*, Feb. 1883) in an article on the above subject, gives a *resumé* of the most recent methods of treatment. Summing up a monograph of Reyher's, he says: That the sooner the wounds of entrance and exit are antiseptically occluded, the better the prospect for life and limb. For wounds resulting from small arms this can be done in either of two ways. The surgeon may occlude the opening with antiseptic materials, and then clean and disinfect the surrounding parts; or he may cleanse and disinfect the bullet tracks, and then resort to drainage. In the vast majority of cases no exploration of any kind should be made; but if the nature of the wound seems imperatively to demand it, the search and all other operative measures should be postponed until they can be done under thoroughly antiseptic precautions, and the wound will then require to be drained. Esmarch says: "The damage done by the bullet is caused by it in its course; the harm that is added comes mostly from the examiner's finger."

Pulmonary Surgery.—Koch remarks that nine years have passed since he brought forward a method of procedure by means of which certain portions of lung tissue, even whole lobes, could be converted into fibrous tissue. He used then a concentrated solution of potassium iodide, but observed that the same end was attainable by means of the galvano-cautery. He pointed out finally that since November, 1873, he had found a considerable number of cases in which the first or milder treatment had been put in actual operation. By means of parenchymatous injections, pure iodine tincture had been introduced into portions of lung where tubercular degeneration had been demonstrated either by physical diagnosis or aspiration. His second plan was to destroy with the galvano-cautery those truly circumscribed tuberculoses of the apex, and especially to treat by these means those processes in the lungs which develop independently of specific infection. After relating two cases in which he had used the galvano-cautery in Prof. Leyden's clinic, in Berlin, he gives the indications for, and the method of employing, the galvano-cautery in the destruction of portions of lung tissue. (1.) In acute gangrene developing from saccular bronchiectases. If a cavity is found during the operation it must be laid open by a more or less capacious passage through the lung tissue, drained and irrigated. When a number of small bronchiectases inter-communicate, they must be converted into one large cavity, and treated in the same manner. (2.) If acute pulmonary gangrene be present, with (as after bullet wounds of the lung) dead and putrid tissue, surrounded by œdematous, hepatized parenchyma, cauterization of the necrotic area, must be freely performed, whilst at the same time a fistula is set up. (3.) A funnel-shaped opening through lung tissue is indicated when a foreign body in a bronchus is not expelled by the natural means, and is giving rise to extensive secondary changes. Koch regards excision of portions of lung unfavorably. In pulmonary prolapse resection is an *operation de luxe*, for we know that such prolapses soon shrivel of themselves; whilst, on the other hand, it is our duty by immediate reposition of the prolapsed portion to prevent any curtailment of the

respiratory area. In cases of bullet wounds of the lung, Koch would resect the ribs and draw the root of the lung forward for inspection. Hæmorrhage being arrested, the lung is to be replaced and the pleural sac drained under antiseptic dressing. [Wm. Koch in the *Separat abdruck aus der Deutsch Med. Woch.*, No. 32, 1883. Quoted in *Edin. Med. Jour.*, April, 1883.]

Treatment of Warts on the Genitals with Chromic Acid.—Dr. Cadell (*Edin Med. Jour.*, April, 1883) advises this treatment instead of the usual one of glacial acetic acid, or nitric acid. It was recommended by Mr. John Marshall as long ago as 1857. One hundred grains of the acid to one ounce of water is a sufficiently strong solution for ordinary cases. The warts should be carefully dried before the acid is used, and afterwards dry cotton wool applied. Dr. Cadell says chromic acid efficiently takes the place of ablation by the knife or scissors, and has the advantage of being a bloodless method, and much less painful. He looks on warts of the genitals and other parts of the body as strictly local in their nature, and believes that the so-called syphilitic warts have no existence.

Treatment of Chordee.—Dr. Cambillard in his *Thèse de Paris*, for 1881, advocates the employment of a solution of potassic bromide to quiet chordee. Every one will admit, he truly says, that the painful erections called chordee are very difficult to relieve, and that the number of remedies proposed is only equalled by their inefficiency. He has obtained uniformly good results from urethral injections of the following: ℞ Aquæ, ʒii; glycerini, ʒiij; potassii bromidi, ʒiss; tinct. opii, ʒi. M. Sig. Four injections of this quantity in twenty-four hours. To prevent the noctural attacks, he insists that the last injection be practiced just before retiring for the night, the injections cause almost no pain, and are very effective in relieving the distress. (*Dublin Jour. Med. Science*, April, 1883). Might not this injection be of service to prevent the erections which occur after the operation of circumcision in adults?

On the Simple Treatment of Congenital Club Foot.—Mr. Edmund Owen (*Lancet*, April 28, 1883) considers that in

most, if not all, the cases of congenital talipes equino-varus, the tendo Achillis is the head and front of the offending. That when this tendon is shortened to the utmost in the elevation of the os calcis, it can contract still further by effecting a rotation of the bone upon its antero-posterior axis, the astragalus also participating in the inversion. In the many cases of slight equino-varus, section of the tendo Achillis will remove the talipes varus, and a prolonged and intimate acquaintance with the employment of plaster-of-Paris has shown Mr. Owen that in many instances of the two-fold deformity of infants division of the tendo Achillis is the only cutting operation required. His method is as follows: About three or four days after section of the tendon, the foot is to be put in a thickish sock which fits evenly and smoothly. Then from about the line of the clefts of the toes to a few inches above the ankle, the foot is to be quickly and firmly encased in the wet plaster bandage, and immediately that the last turn is finished, the foot is to be forcibly manipulated, so that as the plaster is setting, it may be steadily held in position towards flexion and eversion. In three minutes or less when the plaster has hardened, the tip of the sock should be cut off in order that the toes may be exposed to view, to allow the surgeon to see that the bandage is not applied too tightly. The plaster should be left on for two or three weeks, and at the end of that time the bandage should be removed, and the foot rubbed with oil and again enclosed as before, only as the plaster is hardening the position of the foot should be absolutely rectified, and again left for two or three weeks and then re-applied. After this the child should wear a stiff leather boot.

This method of treatment is not altogether novel. Dr. T. G. Roddick read a paper in 1880 before the Medico-Chirurgical Society of Montreal, which was published in the *Can. Med. and Surg. Jour.*, 1880, on the treatment of club foot by plaster-of-Paris. His method differs from that of Mr. Owen's in that he applies the plaster-of-Paris directly to the skin, and after dividing the tendo Achillis he maintains the foot in position by strips of rubber adhesive plaster.

Reviews and Notices of Books.

The Systematic Treatment of Nerve-Prostration and Hysteria.—By W. S. Playfair, M.D., F.R.C.P., Professor of Obstetric Medicine in King's College; late President of the Obstetrical Society of London, etc. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Bros.

Dr. Playfair is well understood to be in England the great advocate of the plan of treatment of inveterate hysteria and neurasthenia so ably brought forward by Dr. Weir Mitchell of Philadelphia,—viz., rest, isolation, massage and electricity. Those who have followed the subject will already have read his addresses, which are here brought together as they have appeared in the *Lancet* and other papers. To any one who has not seen these articles, this book will prove highly interesting, as it contains the author's views with reference to the proven possibility of, in this way, restoring to friends and usefulness women otherwise condemned to a valetudinarian and worse-than-useless existence. He strongly corroborates the teachings of Weir Mitchell, and insists that each part of the treatment must be carefully carried out in order to ensure success. The difficulties of diagnosis and the care that must be exercised in this respect are specially alluded to. An appendix contains a description of the exact manner in which the massage is carried out.

Students' Guide to Diseases of the Eye.—By Edward Nettleship, F.R.C.S., Ophthalmic Surgeon to St. Thomas' Hospital for sick children. Second American from the second revised and enlarged English edition; with a chapter on Examination for color perception. By William Thomson, M.D., Professor of Ophthalmology in the Jefferson Medical College. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Bros.

Very considerable alterations and amendments have been made in this second edition, the calling for which within a year of the original publication shows that it has been appreciated.

Its success no doubt depends upon the fact that it is complete in all points, but concise and as free as possible from all unnecessary ophthalmological refinements and minutiæ. It is just the book for a student, and for the general practitioner it is an excellent and safe guide for the practical management of all ordinary cases of eye disease.

A System of Human Anatomy, Including its Medical and Surgical Relations.—By Harrison Allen, M.D. Professor of Physiology in the University of Pennsylvania, etc. Illustrated. Section IV. Arteries, Veins and Lymphatics. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Bros.

This new and valuable treatise on anatomy by an American author, is being rapidly brought out. We have already had occasion to speak in high terms of the preceding parts, and can say now without hesitation that the more we see of it the better we like it. This remark applies both to the letter-press which, drawn on new lines, gives much information to the reader, that is not to be found in any of the ordinary text-books, and also to the colored plates which are numerous, accurate, and executed in admirable style. When complete, Dr. Allen's work will be an ornament (a *useful* ornament) to every physician's library.

Scrofula and its Gland Diseases—An Introduction to the General Pathology of Scrofula, with an Account of the Histology, Diagnosis, and Treatment of its Glandular Affections.—By Frederick Treves, F.R.C.S., Eng. Assistant Surgeon to, and Senior Demonstrator of Anatomy at, the London Hospital, etc. Philadelphia: Henry C. Lea's Son & Co.

This is one of the cheap series published by the well-known Philadelphia firm, and may be had for the modest sum of ten cents. It is an excellent scientific modern treatise on what continues to be one of the most interesting subjects in all pathology, viz., the true nature of scrofula and tubercle. Interesting as these points are in their discussion to all earnest

physicians, yet even still more important to practical men is a knowledge of the characters and diagnosis of the scrofulous affections of the external glands. These matters are here thoroughly discussed, and the appropriate treatment clearly pointed out. It is a useful and instructive book for any student or medical man to have and—to read.

Books and Pamphlets Received.

Handbook of the Diagnosis and Treatment of Diseases of the Throat, Nose and Naso-Pharynx. By Carl Seiler, M.D. Second Edition. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Bros.

A Treatise on Insanity in its Medical Relations. By William A. Hammond, M.D. New York: D. Appleton & Co. Montreal: Dawson Bros.

Illustrated Medicine and Surgery. Vol. II.; No. 2. New York: E. B. Treat.

Medical Essays. 1842-1882. By Oliver Wendell Holmes. Boston, Houghton Mifflin & Co. Montreal: Dawson Bros.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, April 13th, 1883.

Dr. Kennedy, President, in the Chair.

Dr. Trenholme exhibited the *Ovaries and Fallopian Tubes* removed from a patient three weeks ago. This is the first time Tait's operation has been made in Canada. The right ovary was cystic, and weighed about one pound; the other ovary and both tubes were normal.

The patient, aged 33, had been a sufferer for the last fourteen years from pelvic derangement, and general prostration of health had followed, so that of late years she was incapacitated for any usefulness in life. The uterus was retroverted and could not be maintained in its natural position. It is too soon to express an opinion as to the results of the operation, but so far everything looks favorable for a perfect cure. The menses have not appeared though four weeks have passed. The abdominal incision was completely united by the third day, and all the sutures removed on the sixth day. She was sitting up on the tenth day, down stairs to her dinner at end of the third week.

Dr. Osler showed the following specimens :—

Aneurism of Aorta, Rupture into Pericardium.—The specimen was taken from a gentleman, about 70 years old, who had never, so far as is known, suffered from any symptoms of heart disease, and had not consulted a medical man. Death took place suddenly while at stool. The sac, as large as the closed fist, was connected with the arch, and projected above and anteriorly, eroding the first piece of the sternum. It was lined with thick laminæ of fibrin. Below, it was attached to the pericardium, and a small rent had occurred 4 by 2 mm., through which the blood had escaped into the pericardium. The valves of the heart were a little atheromatous and the muscles very fatty.

Double Hernia.—From a man aged 80, an inmate of the House of Refuge, who had died of cerebral softening. There was double inguinal hernia, both the sacs very large. The left one contained the whole of a very long and lax sigmoid flexure, which was full of hard scybalous masses ; the right sac contained the cæcum and appendix, the first three or four inches of the colon, and the last twelve inches of the ilium.

Puerperal Convulsions, Ventricular Hæmorrhage.—Dr. Osler showed the specimen taken from a primipara in ninth month, aged 40, who was admitted to the Lying-in-Hospital on 23rd of March. Seemed pretty well, but at times acted strangely ; had been intemperate, never complained of swelled feet. Thursday, April 5th, she seemed as well as usual, and ate heavy meals. A little after 11 p.m. she vomited, but after 2 a.m. laughed and talked with the other patients. At 3.30 a.m. she was found sitting up in bed with the chamber-pot between her knees. Soon after, she had a convulsive seizure, became profoundly comatose, and died at about 5 a.m. The urine was drawn off and found loaded with albumen, and contained numerous casts. At the autopsy the condition of the brain as here seen was found. An extensive hæmorrhage had taken place into the ventricles, and the clots form perfect casts of the lateral, 3rd and 4th ; that in the left lateral is the largest, and the blood has come from the corpus striatum of this side, the intra-ventricular portion of which is swollen and infiltrated with

clot. In the uterus there was a mature fœtus. The kidneys were enlarged, congested, and the tubules of cortex swollen; epithelium cloudy and granular.

Fibroid Heart and Atrophic Kidneys.—The specimens were taken from a man aged about 80, who died of softening of the brain (thrombotic) in the House of Refuge under Dr. Burland's care. The left ventricle presents, as seen in the specimen, a large area of fibroid degeneration occupying the usual position at the apex and lower part of the septum. The valves were all thickened, but the atheromatous changes in the aorta were slight. The kidneys show advanced senile atrophy, cortices much reduced, pelvic fat greatly increased, arteries very prominent.

Dr. Roddick read a short paper entitled "*Notes on Hare-Lip.*" (*See page* 594.)

Dr. Fenwick asked Dr. Roddick how to get over the fact that you have rudimentary teeth in intermaxillary bone? Rarely met with a case without these rudimentary teeth.

Dr. Blackader reported a case in point through alveolar border —operated on by Dr. Roddick with excellent results. Suggested the feeding of these cases with cream and lime water.

Dr. Hingston agreed in general with paper, but there were some features to which he did not assent. First, as to life, he thought the selection of the second or third month of infantile life somewhat arbitrary, and preferred to operate immediately after birth. His success was almost in direct ratio to the early period at which the operation was performed. If a few months elapsed before seeing the child, he preferred waiting till after teething. He was not in favor of the hare lip pin, and had discarded it nearly twenty years ago. He had found that at the point of entrance and of exit marks were left, and if the pin were left four days, as recommended by the reader of the paper, the marks would necessarily be unseemly. He preferred wire sutures, but relieved tension on them by the plasters on the cheek of a deltoid form, broad behind and drawn towards each other by wire. Wire had an advantage over thread; as the plaster yielded, a twist or two made all tight again, whereas loosening a knot and retying disturbed the parts, and sometimes

occasioned separation. He thought no general rule could be laid down as to treatment of the inter-maxillary bone. Generally it could be utilized, and in this he agreed with Dr. Roddick, rather than with Dr. Fenwick, and the danger of having the teeth which might be growing in it turning back, as alluded to by one speaker, was chimerical, as the bone was merely brought back to its normal position. Where the hard palate was separated, treatment necessarily varied. Where the fissure was wide, Langenbeck's uranoplastic operation had to be deferred; but where the fissure was narrow and of uniform width throughout, the operation could safely be performed immediately after birth, paring the edges of the fissure, pressing the maxillary bones together, and retaining them *in situ*. Of the latter operation, however, he had not sufficient experience to warrant him in giving it preference over the later uranoplastic.

Dr. Henry Howard spoke of a case operated upon at birth where there was double hare lip with cleft palate with good results. Dr. Shepherd asked for statistics as to heredity. Dr. Hingston denied heredity, but accepted nervous influence. Dr. Roddick made a few remarks in reply to members who had spoken on the paper. As to the question of heredity, the last case on which he had operated bore out the law, the grandfather of the child having suffered from hare lip. Notwithstanding the strong ground taken by Dr. Hingston in favor of operation immediately after birth, he still thought that in the vast majority of cases it should be deferred for at least three or four weeks.

Dr. Trenholme related a case of *Utero-tubal Gestation*, where the use of the sharp curette was followed by the escape of a dead embryo *into*, and then from, the uterine cavity. This was the second case of irregular gestation he had met with this winter. It was of special interest as shewing what can be done in those cases where the fœtus is partly within the cavity of the uterus. The patient made a good recovery.

Dr. Shepherd mentioned having lately seen a boy eight years of age suffering from chancroid and gonorrhœa.

The Secretary, Dr. Henderson, handed in his resignation, which was accepted. A resolution was passed by the society to

to present Dr. Henderson with an illuminated address, expressing appreciation of past services and good wishes for future success in his new sphere of labor.

Dr. Gurd was appointed Secretary, and Dr. J. Leslie Foley, Librarian.

Stated Meeting, April 27th, 1883.

The President, R. A. Kennedy, M.D., in the Chair.

Case for Localization.—Dr. Osler presented a patient with the following history: Francis ——, aged 41, married fifteen years. Not known to have had syphilis, though he lost one child shortly after birth with a skin eruption. Has enjoyed good health, with exception of present trouble. For six years he has had epileptic fits; at first at rare intervals—one in three months—but now one every fortnight. Liable to have them at any time if much excited. They are, his wife says, confined to the right side, towards which, also, he tends to fall. Not known whether they begin in hand or foot, as he has not had a fit since under observation; always loses consciousness. Nearly two years ago he began to have trouble in the right leg, jerkings and stiffness, which have steadily increased. The right arm was also weak, and for the past five months the speech has been affected. His memory is not so good as it was, and at times he is irascible. He has had two injuries to the head; the first when a lad of seven or eight, which has left a long scar on the right side, high on the parietal bone. There is no adhesion of the skin and no depression. The other was received by the fall of a scantling, seventeen years ago, and is a flat scar a little behind bregma on the left parietal bone. It is not depressed, and the skin not adherent. At present, nutrition of muscles good; he walks with difficulty, owing to stiffness of right leg, in which the spastic gait is well marked. Reflexes greatly increased in the leg. Knee-tap somewhat exaggerated also in the left. Right arm does not appear much affected, but he says it feels weak. Grip is good; dynamometer shows it to be a little weaker than the left. Slight paralysis of lower facial muscles; tongue deviates strongly to the right, uvula drawn towards the

left. Speaks with hesitancy, and is often at a loss for a word. No impairment of sensation. No optic neuritis or retinitis. The patient's head was shaved and Broca's lines drawn, in order to define the exact position of the old injury on the left side. It is just behind the bregma, and would correspond on the cortex of the brain to hinder part of the superior frontal convolution. The symptoms point to a lesion of the motor area on the left hemisphere, situated about the upper end of the fissure of Rolando, along the ascending frontal, and extending to the inferior frontal sinus. The character of the convulsive seizures, unilateral, the monocrural rigidity, the dissociation of the paresis, leg and face, and gradual extension, point to a cortical lesion; but whether connected in any way with the old injury is somewhat doubtful. The question of trephining in such a case naturally suggests itself, and may come after further study of the case.

Dr. Roddick stated that he had known the patient for some time, and he had suggested the advisability of trephining at the site of the old injury, but had been overruled by his colleagues.

Chyluria, not Parasitic; Autopsy.—Dr. McConnell read the report of the case. A woman, aged 33, native of the Province; married ten years, two children. Eleven years ago she noticed that the urine was milky. Had been healthy up to that time, but ever since had not been so strong. The white appearance of the urine has persisted with occasional periods of intermission, two of which were while she was pregnant. Came under observation on October 27th. Was pale, anæmic, moderately emaciated. Appetite good, is constantly hungry, and eats five or six meals a day; sleeps well; bowels very constipated. Has to make water very frequently, nearly every half hour, and is of the color of milk. Sometimes very painful to pass from the presence of thick, clotted portions. A sample passed was quite fluid when fresh, but in a few minutes a large part of it curdled. Examination of abdominal organs negative. In chest, râles at apices of lungs. On three occasions the blood was carefully examined by Dr. Osler and myself, a number of slides at a time, and the blood taken after midnight, but no filarian embryos were

ever discovered. The quantity of urine passed was estimated for several days, and ranged from six to eight quarts; often the clots were blood-stained. Microscopically, it presented fatty molecules, like the molecular base of the chyle, a few blood-cells and leucocytes. Repeated examinations failed to detect any parasites. The condition of the patient grew gradually worse through the winter; the cough became more distressing, and the digestion much impaired. Death took place on the 5th of March. For three days before dissolution, the urine was bloody and not so abundant. The *post-mortem* was held on the 18th inst., the body, which had been in vault of the cemetery, was in a good state of preservation. A careful dissection was first made of the thoracic duct and receptaculum, but, as the specimen shows, it appeared perfectly normal, perhaps a little small, but pervious throughout, and contained a bloody lymph. No dilated lymph vessels about the kidneys, or any special connection between renal and abdominal lymphatics. The mesentric and retro-peritoneal glands were a little enlarged and firm, and, on section, presented opaque areas of fatty degeneration. No caseous or calcareous glands. Lacteals not distended. Kidneys were of average size, capsules detached easily, substance a little blood-stained, but looking very natural. Ureters normal. Bladder contained six or eight ounces of bloody fluid, which had clotted. Mucosa normal. Inguinal and pelvic lymph glands not enlarged. Tubercular cavities at apices of lungs, and a few ulcers in the ilium. The lymph glands, retro-peritoneal tissues, mesentery, and kidneys were subjected to prolonged microscopical examination without producing a trace of anything parasitic, or, indeed, of anything which threw any light on the nature of the affection.

Dr. Roddick asked if it were not possible that in the course of the disease the filaria might disappear?

Dr. Osler thought it not probable, without leaving some trace of the presence of the adult worms which live in and about the lymph glands in pelvic and peritoneal tissues. The value of this case was considerable, as it showed that we should not regard, as some recent writers do, chyluria and the filarian disease as identical.

Inflamed Umbilical Hernia.—Dr. F. W. Campbell read the notes of the case: Stout woman, aged 64, had had irreducible umbilical hernia for fifteen years. Had been seen four years ago, with a painful attack in the hernia which subsided in a few days. On the morning of April 9th, was sent for, and found her suffering great pain in the sac. The pad had got off, and without waiting to replace it, she had jumped out of bed, and was at once seized with severe pain. The hernia has been getting a little larger of late, and the pad was too small. It was at once reduced to the usual size without difficulty, but the pain continued. Liq. opii sed. was given. An enema brought away many scybala. In the afternoon, she was not so well, and vomiting set in. On the 10th she was easier, and on the 11th pain was well kept down, but the vomiting was excessive. An injection brought away a large fecal stool. Had a restless night on the 12th; pain has returned, but not so severe.

Was seen by Drs. Howard and Fenwick, but it was decided that the symtoms scarcely justified an operation. Through the 13th and 14th she kept about the same; the vomiting not so frequent; and on the evening of the 14th she seemed very much better. Early in the morning of the 15th she got much worse, became cold, sank rapidly, and died in a few hours. The autopsy showed a thin-walled umbilical sac, not inflamed. In it were two coils of intestine; one, about thirteen inches in length, was dark-colored, deeply congested, and inflamed; the other, nine or ten inches in length, was natural looking, though a little swollen. Two fingers could be passed into the ring; there was no strangulation. There was no adhesion of the bowel to the sac. The inflamed portion of the bowel presented two flat bands of slightly thickened peritoneal tissue, where it has been probably for years in contact with the ring. The inflammation had extended along the adjacent coils in the abdomen for a few inches. When slit open, mucosa intensely inflamed, of a deep, livid-red color, and covered with closely adherent flakes of croupous exudation. Heart fatty. No other changes of note.

A difference of opinion had existed regarding the existence of strangulation in this case, and the propriety of operating. From

the *post mortem* appearance, it did not seem probable that nipping of the bowel had occurred, as the ring was large, and a healthy coil was in the sac. It may have been simply the result of a primary inflammation of the hernial coil, which had evidently been in the sac for years, as it was dark with pigment. One of the most inexplicable features of the case was the sudden heart failure; but she had been taking very little nourishment, and the vomiting had reduced her strength very much.

Cancer of the Stomach.—Dr. Wood presented the specimen and narrated the case. A woman, aged 55, had suffered for a year or more with dyspeptic symptoms, and two months ago had vomited a small amount of blood; had lost flesh, but was not cachectic. No tumor of abdomen could be made out, but cancer of the stomach was suspected. The details of the last week of her illness are as follows: On April 14th, 15th, and 16th, she had a good deal of nausea and vomiting; on the 17th she went to bed and I saw her for the first time in several weeks. There was vomiting and considerable epigastric pain; pulse about 90. On the 18th she was easier; 19th much worse; fainted in the night; pulse weak, 115; face pale, feet cold, vomiting frequent. In the evening the temperature was 101°; pulse, 120; the pain in abdomen was more diffuse, and there was considerable distention. On the 20th, condition did not improve, though, under opium, the distress was not so great. On the 21st prostration more marked, and the next day the vomiting was distinctly fecal and frequent. Death on the 23rd.

At the autopsy, the small intestine from an inch or two below the duodenum to within two inches of the valve, was dark in color, distended, and covered in places with a thin sheeting of lymph. Several spots in the ileum looked almost gangrenous, and here and there extravasations had taken place. The coats were infiltrated, the mucosa soft, and there were three spots (ulcers) from which the membrane had disappeared.

The stomach, as shown by the specimen, presented a large open cancer, involving the cardiac end, and completely encircling the organ. Several loose sloughs adhered to the surface, but over a great part of its extent the muscle fibres were bare.

There was thickening of the peritoneal surface and a few secondary nodules. In looking for the cause of the condition of the bowel, the vessels were carefully examined, and the superior mesentric artery found to be plugged.

Sarcoma of Kidney in child 5 years of age.—Dr. Alloway briefly related the following history of this case :—The disease, when first noticed, appeared as a tumor, extending from below the ribs to within an inch of the crest of ilium, on the right side. The growth gradually increased during the next three months, until, at death, it filled the whole abdominal cavity. The tumor weighed nine pounds, and was, on microscopical examination, found to be a round-celled sarcoma.

Dr. Osler also exhibited *Scirrhous disease of pancreas and colloid lung*, taken from the same patient, and the *kidneys* from a man found in a comatose condition outside the city. He was brought first to a police station, and from there sent to hospital. He never became conscious, but died a few hours after entering hospital. Albuminuria was suspected ; the catheter was used, and urine loaded with albumen withdrawn. The kidneys were about normal size, and but slightly congested.

Dr. Shepherd then exhibited specimens as follows :—

1. *Abnormalities of Aortic Arch.*—(*a*) A case of large middle thyroid artery. It passed up the middle of the neck lying on the trachea, and divided about half an inch below the cricoid cartilage into two branches, which went to right and left side of the trachea. (*b*) Two examples of the left carotid arising from innominate artery instead of from the arch. This was mentioned as being the normal arrangement in many animals, as the dog, rabbit, &c. (*c*) One example of a left vertebral arising from the arch of aorta instead of from the subclavian. It was of large size. The right vertebral was very small, not being larger than a crow quill. The branches from the right subclavian in this case came off separately, no thyroid axis being present.

2. *Persistence of the Left Duct of Cuvier, or double superior vena cava.*—This specimen was obtained from a female subject aged about 65. The vein was about the size of a pen-handle. The left vena innominata was not much reduced in size, as is the

case when the persistent duct is large. This was the second example of this anomaly that Dr. Shepherd had met with. The left duct of Cuvier persists normally in birds and some mammals.

3. *Dissection of a case of Talipes Varus.*—Dr. Shepherd obtained this specimen from a subject in the dissecting room, aged about 45. The foot had never been operated on, and was a pure case of talipes varus. The deformity was due principally to the contraction of the tibialis anticus, extensor proprius hallucis, and extensor communis digitorum tendons.

4. *A preparation of an abnormal right obturator artery* given off from the epigastric and passing to the inner side of the femoral ring.

5. *An inferior Maxilla*, having a large sinus in the body leading down to the decayed root of an incisor tooth.

6. *The Uterus of a young girl*, aged about 16, which had the os uteri so narrowed as to admit a fine probe with difficulty.

(*To be continued.*)

Extracts from British and Foreign Journals.

Unless otherwise stated the translations are made specially for this Journal.

Deafness After Mumps.—One of the most formidable sequelæ of this common affection is sudden and permanent deafness of one or both ears. Several instances of this have recently been reported. Knapp in the last number of the *Archives of Otology* records a case in which the deafness was absolute in both ears and without evidence of any middle ear affection. The hearing was lost on the eighth day of the attack, and was preceded by earache and headache and dizziness. She could hear nothing either by ear or bone conduction. He regards the lesion as labyrinthic, but impossible to say what the nature may be—whether hæmorrhagic or purulent. Seitz (*Centralblatt*, No. 5, 1883) has reported a case in which deafness in the right ear, with dizziness and tinnitus, came on upon the 7th day, and the hearing was permanently lost on that side. He regards it as due to a secondary inflammation of the labyrinth, with a copious serous exudation which rapidly destroys the delicate structures of the inner ear.

Congenital Malformations of both Knee-Joints.—Mr. Hubert Sells, Senior Resident Obstetric of Guy's Hospital, describes the following case of malformation in a new-born infant, very fairly developed: On looking at the lower limbs, the first thing that struck one was, that the patellæ on both sides were apparently missing, and in their place was, on each limb, a depression. The description of one limb will suffice for both. The movements of the hip-joint were complete. The thigh, instead of being convex, was slightly concave on its anterior aspect. The tibia and fibula were in their normal relative positions. The foot looked forwards naturally, and the ankle-joint was normal. The patella was placed at the back of the joint instead of in front. In the normal position of the patella was the depression above mentioned, which apparently represented the popliteal space, as the continuation of the femoral artery could be felt pulsating here, and there were some tendons on either side of it, analogous to the ham-string tendons. There was also, running down a little to the inner side of centre of this space, a strong tendon, which was continued downwards to the head of the tibia, and may have been the representative of the quadriceps extensor tendon. Posteriorly, the patella was rather firmly fixed, nearer the femur than the tibia, in a strong tendon, so that the impression at first was that it (the patella) was attached by osseous tissue to the femur. This idea was, however, dispelled on moving the joint. The movements of the knee-joint were perfect but reversed. The tendon in which the patella was fixed was exactly like the ordinary extensor tendon of the thigh. The artery could not be traced below the head of the tibia. It may, I hope, be seen from the above description, that the leg could be flexed on the thigh anteriorly, as much as it would have been posteriorly in the normal state. When the child was first seen, it had the toes of one foot almost in its mouth, which of course, it could reach easily without flexing the thigh. The child died on the third day after birth, and, unfortunately, the parents would not consent to a *post mortem* examination.—*British Medical Journal.*

Funnel-Drainage in Anasarca is a method of removing large quantities of fluid devised (*Glasgow Medical Journal*) by Dr. Straub, Tübingen. It is simpler and affords more relief in equal time than Southey's. The apparatus consists of an ordinary glass funnel, of two inches diameter, attached to the end of which is an India-rubber tube one eighth inch in diameter, and long enough to reach to the floor. If the apparatus is filled with water, and the mouth of the funnel firmly applied to the skin of a patient lying in bed, while the end of the tube is immersed in a vessel on the floor containing a little water, it will be found to adhere quickly and act as a sucker; and when the funnel is applied over several small incisions or punctures in a case of œdema, the tube acting as a siphon will keep up a continuous drainage of serum into the vessel. The force of the suction can, of course, be regulated by altering the level of the vessel, and the flow of fluid can be watched by a piece of glass tubing let into the India-rubber tube. The apparatus, if protected by a small cage or cradle, can be left on for any length of time, and is not displaced by movements of the patient if ordinary care is taken. Enormous quantities of serum have been drained off in this way. In one case of chronic Bright's disease there were drawn off in two and a quarter hours, over seventy-eight ounces; in seven hours, over ninety-six ounces; and in twenty-four hours two hundred and seventy-eight ounces; and in another case of extreme general dropsy from Bright's disease, nearly forty-three pints were removed in seventy-nine hours.—*Gaillard's Medical Journal.*

Tubercle Bacilli in the Urine.—Professor Rosenstein of London has been able to determine (*Centralblatt*, No. 5, 1883) the presence of these structures in the urine of a man with nodular masses in the epididymis of either side, but no signs of lung affection. The greyish white sediment dried on top covers, and treated by Ehrlich's method, showed the tubercle bacilli with distinctness. As a means of diagnosis in obscure renal affections, with muco-purulent urine, this may prove of great use.

CANADA

Medical and Surgical Journal.

MONTREAL, JUNE, 1883.

THE TRIENNIAL MEETING.

It is nearly three years since the present Provincial Board was elected in Montreal, and we shall be called upon to choose their successors in Quebec on the 11th July next. It is to be hoped that a large meeting will be collected there on that day. Every one who is unable to attend should take care to send his proxy to some friend. To avoid mistakes we would draw attention to the section of the law on this subject. To be valid, it is necessary for a proxy to be in the hands of the Registrar, on or before the 1st July, it being his duty to certify that the signer is a Licentiate, and to return the document five days afterwards. Any one in arrears, moreover, is not entitled to vote.

We are convinced that far more interest would be taken in these elections if the Province were divided into electoral districts, the members in each of which would elect their own representatives. As it is, a great many feel that the nominations for this large Board really lie in the hands of a comparative few, and that their presence, or the casting of their vote, cannot be of the least consequence. It is a matter for regret that any such feeling should exist, for the Province will never be (medically) so well governed as when each individual member is made to feel the greatest interest in the selection of the best local member to represent that section on the governing board. We have already given our views upon this subject, and we believe it would be for the general good if some one would raise the question for discussion at this meeting.

As regards the outgoing Board, we think they are entitled

to credit for the manner in which their duties have been performed during the past three years. The semi-annual meetings have been conducted in a business-like manner, the matters brought before them have been discussed in a fair and judicial spirit, and the decisions reached have given general satisfaction. A competent and active person has been appointed for the prosecution of quacks, and several convictions obtained. Indeed, at the present time, few places are as free from these obnoxious persons as the Province of Quebec. The assessors of the College have duly visited at the examinations of the different Universities, and complete harmony between these bodies and their official Provincial superior has existed. We congratulate the retiring President upon this satisfactory state of things, and trust that his successor may have an equally prosperous and peaceful reign.

PROFESSOR MacCALLUM.

We have already announced, amongst the changes recently brought about in the Medical Faculty of McGill College, the resignation of Dr. MacCallum. After having faithfully served the University in several capacities for a long series of years, he only quitted his post when he felt that he was fairly entitled to devote more of his energies to his private *clientèle*. His colleagues part from Dr. MacCallum with great regret, and they, as well as the governors of the University, have, by resolution, expressed their opinion of the services he has rendered during his term of office. These resolutions are as follows :—

At the meeting of the Medical Faculty, it was

Resolved,—That this Faculty accept the proffered resignation of Prof. MacCallum, a step which has been forced upon him by the increase in his private engagements, and his inability both to satisfy so many claims upon his time and to continue engaged in the arduous work of regular instruction. That in so doing, they desire to place upon record their deep appreciation of the many excellent qualities found in him, so recently their colleague, qualities which have enabled him to fill most important chairs in this University during a period of twenty-nine years, with the

highest credit to himself and the happiest results to those privileged to receive his teaching; and in parting with Prof. MacCallum as an active member of the Faculty, they feel the loss of one whose best exertions have always been placed at their service, and whose every energy has always been used to render his department thorough and efficient. That as a slight recognition of his long and faithful services to the University, the name of Prof. MacCallum be recommended for the honorary title of Emeritus Professor.

At the meeting of the Board of Governors, it was

Resolved,—1*st*. That the resignation of Dr. D. C. MacCallum of the Chair of Midwifery and Diseases of Women and Children be accepted. 2*nd*. That this Board desires to record its sense of the long and able services of Dr. MacCallum as a Professor in the Faculty of Medicine, and to express its great regret that it should have become necessary for him on account of the arduous duties of his profession to retire from the Chair of Midwifery he has so ably filled. 3*rd*. That Dr. MacCallum be, and hereby is, continued as Professor Emeritus in the Faculty of Medicine, retaining his present precedence in the University.

Chair of Anatomy.—Dr. F. J. Shepherd has been appointed to the Chair of Anatomy in McGill College, made vacant by the death of Prof. Scott. The length of time during which Dr. S. has acted as Demonstrator of Anatomy in this university (8 years) renders him particularly well qualified to enter upon the important duties of this chair, and the success which has attended his teachings hitherto will no doubt continue to follow him in the higher sphere. Dr. Richard MacDonnell has been made Demonstrator of Anatomy and Dr. R. J. B. Howard assistant Demonstrator.

Montreal General Hospital.—The contest for the post of attending surgeon, made vacant by the resignation of Dr. Wright, was filled by the Governors on the 17th ult. The candidates were Dr. Shepherd, outdoor surgeon, and Dr. F. W. Campbell. We have already expressed our opinion upon the

superior fitness of the former, and it is with pleasure we record that Dr. Shepherd was elected by the Governors by a considerable majority. We congratulate the doctor upon his appointment, one to which he was fairly entitled by well performed hospital service in the surgical department for several years, and which he is well qualified to fill with credit to himself and usefulness to the hospital and its reputation. On the same day, to fill the vacancy created by the promotion of Dr. Shepherd, Dr. Richard MacDonnell was made one of the attending physicians to the outdoor department.

ONTARIO MEDICAL ASSOCIATION.

THIRD ANNUAL MEETING.

The third annual meeting of this Association was held in Toronto on the 6th and 7th inst. Dr. Macdonald, the President, owing to indisposition, was unable to attend on the first day, and Dr. Richardson was voted into the chair.

In the afternoon session, Dr. Burt exhibited a patient treated for traumatic tetanus by neurotomy, and Dr. Campbell a case of primary lateral sclerosis.

The following papers were read: "On the use of Jaborandi in certain cases of Fever," by Dr. McKay of Woodstock; "On Fatty Diarrhœa," by Dr. Woolverton of Hamilton; "On the Removal of an Ovarian Tumor," by Dr. Grove of Fergus; and "On Fracture of the Forearm," by Dr. McNaughton, the latter exhibiting a new splint which restored the radial curve of the arm.

Dr. Clark of Kingston read a paper on "Anomalous cases of Nervous Disease," and gave a history of one of hystero-epilepsy.

Dr. Workman read a paper on "Aphasia."

Dr. Graham read a paper on "Bacillus Tuberculosis," and gave the results of the examination of the sputa of 40 patients which he had examined. The conclusions arrived at by the doctor from the experiments were: 1st, That bacilli are found in the sputa of almost, if not all, cases of phthisis; it was doubtful if there was any case of active disease in which bacilli will not be found, provided the sputa came from the lungs, and five or six examinations were made. 2nd, They were found on the first

examination in three-quarters of the cases. 3rd, The presence of the bacilli is a positive evidence of the disease. 4th, There are doubtful cases in which the examination of the sputa for the bacilli will be of decided value in arriving at a correct diagnosis. 5th, As to prognosis, it was found that the number was in proportion to the amount and rapidity of the process of destruction. 6th, It might be said as a general rule that in the more chronic cases bacilli were fewer, and, he thought, smaller. His experience convinced him of the contagiousness of the disease, of which he gave instances.

Dr. F. N. Strange then read a paper on "Acetonæmia." He gave the history of a case which had come under his own observation, with that of a similar one recorded in England. The opinion was expressed that the coma of diabetes is due to chemical reaction of the blood.

On the second day, the Secretary read a paper by Dr. Battersby of Port Dover, on " Umbilical Hernia," and Dr. Mitchell one on " Some cases of Poisoning," one by carbolic acid and two by Paris green.

Dr. Macdonald, the President, then delivered his annual address. He enumerated the advantages to be derived from the meetings of the Association, both from a social and professional point of view. Ontario being a large province, the members of the Association suffered from isolation, and the reunion brought about by the meetings of the Association tended to bring the members of the profession who lived at a distance from one another into closer social relations, and aid much to remove the feeling of distrust that was supposed to exist in their ranks. The Association also was intended to fill the gap between the Dominion Association and the local organizations of the town and country. He thought that London and Kingston should be visited every year alternately with Toronto by the Association, as such a course would extend the benefits derived from their meetings over the province. He then referred to the question of the attitude to be assumed by the members of the profession towards the Homœopathists in consultation. There was not that hostile feeling towards the disciples of Hahnemann in Canada that was

felt in the United States, a result owing probably to the terms on which Homœopathists were received by the Medical Council of the College of Physicians and Surgeons. But, although there was no hostility, there was no change in the opinion in which the doctrines of Hahnemann were regarded by Allopaths. He thought they should do nothing that would throw obstacles in the way of others giving professional aid in the cases of urgency when Homœopathists were called in in consultation. He alluded incidentally to the museum proposed to be started by the Association, and mentioned the advantages which would result from such an institution. He had no doubt that the College of Physicians and Surgeons would find the room required for such a museum if it were started.

The following papers were read: "On Cancer of the Pharynx," by Dr. Ryerson; "On Hip-Joint Disease," by Dr. Ferguson; "On a supposed case of Super-Fœtation," by Dr. Davison of Toronto; "On some cases of Enteric Fever," by Dr. Cassidy.

Dr. Oldright presented the report of the Committee on Sanitary Science.

This matter was subsequently referred to a special committee as recommended.

A report on Medical Ethics was presented by the committee in charge of the subject, and there being no time for discussion, it was referred back to the committee.

The Nomination Committee recommended the following officers for the ensuing year:—President, Dr. D. Clark; Vice-Presidents, Drs. Worthington, Philps, Richardson and McGill; Secretary, Dr. J. C. White; Treasurer, Dr. J. E. Graham.

A resolution was adopted pressing upon the attention of the Government the necessity of having Boards of Health and Medical Health officers in the local municipalities.

In the evening a conversazione was held, which was attended by about eight hundred visitors.

MEETING OF THE AMERICAN MEDICAL ASSOCIATION.

Held at Cleveland, Ohio, June 5th, 6th and 7th, 1883.

The Association, to the number of about one thousand, met in the Case Hall on the morning of the 5th, and was called to

order by Dr. X. C. Scott, Chairman of the Committee of Arrangements. After a few remarks from the President of the Association, the venerable John L. Atlee, General Edward S. Meyer, an eminent lawyer of Cleveland, delivered a most eloquent address of welcome. Then followed the annual address by the President, who referred at some length to the study and practice of medicine as he knew them about the year 1815-18. One of his preceptors was the celebrated Dr. Physic, of Philadelphia, regarding whom some interesting reminiscences were given.

The afternoon was devoted to work by the sections. In the medical section nearly the whole time was taken up with a discussion on "Yellow Fever," a paper having been read on that subject by Dr. Robt. D. Murray, of the Marine Hospital Service. In the section on Surgery and Anatomy, Dr. Dudley P. Allan read a very able and interesting paper on the comparison of "Antiseptic and Non-Antiseptic Methods of Treatment." Dr. Allan is a thorough convert to Antiseptic Surgery, but is undecided as to whether the spray as employed by Lister or *irrigation* as used by Volkmann affords the better protection against the entrance of micro-organisms into wounds. In the discussion which followed many members took part and others had signified their intention to do so, but owing to the length of time occupied by some of the speakers in making their remarks, and the short time at the disposal of the section, the debate was brought abruptly to a close by the chairman.

The paper which next engaged the attention of the surgeons was read by the venerable and esteemed Prof. S. D. Gross, of Philadelphia, on the "Value of early and late Operations in Morbid Growths, especially Malignant." He laid great stress on the necessity of a correct diagnosis between benign and malignant tumors, especially of the breast, although he frankly admitted that in not a few cases the best of surgeons were sometimes puzzled, in which case the patient should get the benefit of the doubt and the whole gland be extirpated. He denounced in the strongest possible terms the practice of those who would operate in cancer, no matter how far advanced. The reader of

the paper took occasion to refer in not very complimentary terms to the charlatanical practice of many who see cancer in every tumor, and who consequently get the credit of curing that dread disease when in reality it never existed.

Dr. Henry A. Martin, of Boston, followed with some remarks on the "Treatment of Synovial Diseases by a New Method." This consisted simply in the removal of the synovial effusion by means of aspiration, and the subsequent application of the rubber bandage which bears his name. He is in the habit also of treating bursal effusions in the same way.

A paper by Dr. R. A. Vance, of Cleveland, was then read, entitled the "Radical Cure of Hernia by a New Method." This proved to be a slight modification of the operation already recommended whereby the skin and subcutaneous tissues are invaginated and utilized as a plug to fill the ring. As the operations, had, however, all been done recently, it was thought by many present that the comparative value of the method could fairly be considered only at a future meeting. Dr. Vance was forced to admit that he already knew of one case where the hernia had recurred.

At the opening of the general meeting on the morning of the second day, the Canadian delegates, Drs. Harrison, Osler and Roddick, were courteously requested by the President to take a seat on the platform. Then followed the report on medicine by Dr. Hollister of Illinois, and that on Obstetrics and Diseases of Women by Dr. J. K. Bartlett of Milwaukee. A lengthy and somewhat animated discussion took place at this meeting with reference to the establishment of an Association Journal. The majority of the members present decided in favor of the project, and that able and experienced journalist, Dr. N. S. Davis, of Chicago, was elected editor almost unanimously.

In the Surgical Section, which was called to order at 2 p.m., there were two papers only which received a lengthened notice, namely, one on the "Treatment of Fractures of the Long Bones," by Dr. J. R. Taylor, of New York, and another by Dr. G. M. Moore, of Rochester, N.Y., on the "Treatment

of Unreduced Cases of Dislocation of the Ulna in connection with Colles' Fracture." Dr. Taylor discards the weight and pulley in the treatment of fractured thigh, and substitutes an extension bar attached above to a species of perineal crutch. In the case of fractured clavicle, he employs a modification of Sayre's method, securing the arm to the side by means of broad straps of adhesive plaster, a large pad being placed over the scapula of the affected side in order to control the movements of that bone. In the treatment of fractured ribs nothing new was suggested beyond this, that the retentive straps should be applied with the arms of the patient raised above the head, as in this position it was thought that the muscular spasm was lessened considerably. Dr. H. O. Marcy, of Cambridge, read a lengthy paper on the "Comparative Value of Antiseptics." There was no new light thrown upon the subject, the experiments and results being almost identical with those already made and obtained by Kock and other investigators. Dr. Lewis H. Sayre, son of the eminent Orthopœdic Surgeon of New York, reported two cases of amputation below the knee joint, that operation being preferred to excision in certain cases of ankylosis.

In the section devoted to children, nearly the entire afternoon was taken up with the discussion on a paper by Dr. Harris, of Virginia, entitled the "Unity of Diphtheria and Membranous Croup." The speakers were pretty evenly divided on the subject, although the weight of argument was probably in favor of the duality theory. Dr. W. H. Myer, of Fort Wayne, Ind., presented a short but interesting paper on "Surgical Treatment of Purulent Pleuritic Effusions in Childhood." After the first aspiration he prefers the exclusive use of the knife and free drainage, being strongly opposed to the method of frequent aspiration so strongly advocated by some authorities. His experience was, however, limited to a single case, so that he could hardly afford to be dogmatical in his opinion.

In the section devoted to Obstetrics and Gynæcology the papers which attracted most attention were the following: "The immediate application of Sutures in Laceration of the Cervix

and Perineum," by Dr. E. C. Dudley of Illinois; "The Restoration of the Perineum by a New Method," by Dr. Marcy, who prefers pins to sutures; and "Enterotomy as a complication in Ovariotomy and Oophorectomy," by Dr. Sutton of Pittsburg.

The resident medicos of Cleveland and the citizens generally deserve the thanks of the Convention for providing a series of the most pleasurable social entertainments it has ever been our privilege to witness. On the evening of the first day a ball and reception were held in the Euclid Avenue Opera House, which was tastefully decorated for the occasion. The guests were received by Dr. X. C. Scott, Chairman of the Committee of Arrangements, assisted by Prof. Gross and Drs. Atlee and N. S. Davis. An elegant supper was served in a most orderly manner in the Roller Rink adjoining, and about 11 o'clock dancing began and was indulged in to a late hour. The Committee also arranged for a series of brilliant receptions to be held each evening at the residences of the most prominent citizens.

The meeting altogether was a great success, and we take this opportunity, on behalf of the Canadian delegates, of thanking the medical men and citizens of Cleveland for the many courtesies extended toward them during their sojourn there.

Obituary.

W. E. SCOTT, M.D.

Since our last issue, in which we had to announce the persistence of most unfavorable symptoms in the illness of Dr. Scott, the fatal termination has occurred. On the 24th of May he breathed his last. During the past winter the Doctor had been somewhat affected by shortness of breath, but always maintained that he was quite well. At the end of March, however, this symptom became aggravated, and he reluctantly agreed to consult a medical friend. It was then found that he had chronic renal disease, and consecutive cardiac derangements. The heart's power was beginning to fail, and dropsy of the extremities very

soon set in. This spread rapidly, and soon became general. Cerebral symptoms showed themselves, and for some days before his death he was only semi-conscious.

Dr. Scott was born in London, England, in 1823. He came to this country in 1831, and adopting the study of medicine, was a pupil, first of Dr. Holmes and then of Dr. McCulloch. He received the Provincial License in 1843, under which he practiced; and was appointed House Surgeon to the Montreal General Hospital, in which capacity he acted during the years 1841-13. In 1844 he received the degree of M.D. at McGill College, and the following year he was appointed Demonstrator of Anatomy. He subsequently held the following chairs in this University, viz., in 1851, Lecturer on Forensic Medicine; in 1853, Professor of Clinical Surgery; and in 1856, Professor of Anatomy—the last-named being that with which he has been so long identified, and which he held up to the time of his death.

Dr. Scott was the senior member of the Faculty of McGill University; he was one of the oldest members of the Board of Governors of the Province of Quebec, and had enjoyed the honor of being President of the same; he was the oldest consulting physician on the staff of the Hospital. Besides these special honorable positions in the profession which he had held, he also filled posts of great trust in the community. Thus he was for many years the surgeon of the 1st Prince of Wales Rifles, and likewise consulting surgeon to the Grand Trunk Railway.

A high-minded, honorable man in all his dealings, a warm friend and generous colleague, Dr. Scott passed a long lifetime, beloved and highly respected by all who knew him. Keen, active, vigorous, he worked away until the very last, although himself painfully conscious of his failing health.

Charles N. Beer.—Of the many industrious, intelligent students who have attended McGill College from Prince Edward Island, few that we remember gave such promise of professional success as Charles N. Beer. For two sessions he worked hard, and became deeply interested in his studies. At the Primary

Examination, he took high honors and the prize in Practical Anatomy. His dissections were among the best that had been seen in the College, and some of them are preserved in the museum. Returning for the third session, he had not been long in attendance when symptoms of pulmonary trouble developed, and at first made rapid progress. For nearly four years he energetically fought his enemy, never relinquishing hope, always buoyed up by the thought of resuming his studies; but at last, on May 24th, he gave up the struggle, and passed among the "inheritors of unfulfilled renown." We extend to his sorrowing family the sincere sympathy of his old teachers.

Personal.

O. H. E. Clarke, M.D. (McGill, '70), has moved from Cohoes to St. Louis, Mo.

Edmund Christie, M.D. (McGill, '82), is practising with his brother in Chicago.

Robt. S. O'Brien, M.D. (McGill, '73), has moved from Grenville, Que., to Nanimo, B.C.

E. J. Laurin, M.D. (McGill, '81), has moved from Virginia City to Deer Lodge, Mon.

George Carruthers, M.D. (McGill '83), of North Bedeque, P.E.I., has left for London, Eng.

J. C. Bowser, M.D. (McGill, '83), and And. Stewart, M.D., have left for London to pursue their studies.

C. J. B. Hanvey, M.D. (McGill, '83), of Cleveland, Ohio, has gone to British Columbia to assist Dr. E. B. C. Hannington.

Drs. Duncan and McLean, late resident medical officers of the Montreal General Hospital, have commenced practice together in Fergus Falls, Minn.

Reuben Levi, M.D. (McGill, '76), J. H. Betts, M.D. (Queen's) and Herbert Mickle, M.B. (Toronto), have been admitted members of the R.C.S., Eng.

D. W. Houston, M.D. (McGill, '81), was in town last month on his way to join the Benedicts. He and his class-mate, J. W. Ross, have established a large and successful practice in Cohoes.

Professor Darling, F.R.C.S., Eng., of the University of New York, was in town last month, and we were very glad to have an opportunity of meeting this well known teacher of Anatomy.

Robt. J. B. Howard, M.D. (McGill, '82), has passed the primary examination for the Fellowship of the Royal College of Surgeons. We see by the *British Medical Journal* that of 56 who presented themselves at this examination only 24 passed.

Dr. McLean of Ann Arbor has been appointed surgeon to the Michigan Central R.R. This will necessitate his resignation of the chair of Surgery in the University of Michigan. He has moved to Detroit. His successor has not yet been nominated.

Dr. T. A. Rodger has been appointed surgeon to the Grand Trunk Railway in place of the late Dr. Scott. This appointment has given great satisfaction to the profession in the city, and no doubt also to the physicians along the line of the Railway. His long residence at Point St. Charles, his successful practice of surgery in this district, and his well-known popularity amongst the *employés* of all classes naturally pointed him out to the authorities as the one to be, as he now is, the right man in the right place.

Medical Items.

Correction.—Dr. Fenwick, not Dr. Arnott, as stated in our last issue, has been appointed to represent the Medical Faculty of Western University, London, in the Ontario Medical Council.

Montreal Dispensary.—In consequence of his appointment to the General Hospital, Dr. MacDonnell has resigned his connection with the Montreal Dispensary, and Dr. Wm. Stephen has been appointed to the latter institution in his stead.

Hospital Internes.—At the annual meeting of Governors of the Montreal General Hospital, held on the 17th ult., the following gentlemen were appointed resident medical officers for the ensuing year, viz., Drs. John Gardner, Wm. Henry and James Gray. They are all graduates of McGill, Class '83.

School of Medicine for Women, Toronto.—The Faculty has been arranged as follows: Dr. Barrett, President and Professor of the Institutes of Medicine; Dr. George Wright, Practice of Medicine; Dr. I. H. Cameron, Surgery; Dr. Adam Wright, Obstetrics; Dr. McPhedran, Materia Medica and Botany; Dr. Duncan, Anatomy and Microscopy; Dr. R. A. Reeve, Diseases of the Eye and Ear; Dr. Krauss, Medical Jurisprudence and Toxicology; Dr. R. B. Nevitt, Sanitary Science, and Mr. Pyne, Chemistry.

—Mrs. Fraser, widow of the late Professor Fraser, has presented the library and surgical apparatus of her husband to the Medical Faculty of McGill College.

—We had an opportunity recently of visiting the celebrated establishment of Parke, Davis & Co., Detroit. Our thought on leaving was: Small wonder that they enjoy the confidence of the profession in an unusual degree.

—The last volume (XV) of the *Encyclopædia Britannica*, just issued, contains two articles of considerable interest to the profession, one on "Animal Magnetism," by Prof. McKendrick of Glasgow, and the other on "Medicine," by Dr. Charles Creighton and Dr. J. F. Payne.

—Rumor has it that a School of Medicine for Women is to be started in Kingston, and the *Canada Lancet* thinks it is not improbable that a second Woman's College may be started in Toronto, as the one at present organized is controlled by men of the Faculty of the Trinity School of Medicine. For the information of the numerous candidates we may state that there is no present intention of establishing such a school in Montreal, Quebec, Halifax, or London, Ont.

—It is a pleasing indication of the advance of Canadian science when our workers enter the field of authorship and achieve marked success. Mr. W. Saunders, of London, Ont., who is so well known to our profession as a skilled pharmacist, has just brought out a work on "Insects Injurious to Fruits" (J. B. Lippincott & Co., Philadelphia), which will take a position with Harris' well known text-book, and be of inestimable service to horticulturists. The volume appears in the best style of the well-known publishing house of Lippincott's, and is illustrated with nearly 500 woodcuts.

—We have frequently prescribed Dr. McArthur's Syrup of Hypophosphites during the past three years with the most favorable results in almost every case. It is a chemically pure preparation, and in our opinion much superior to similar preparations found in the market. Give it a trial if you have never used it.—*Dr. R. H. Andrews, in Medical Summary.*

Glycerole of Celery Compound.—This safe mixture (containing no opium) for the relief of infants fretting, and for adults suffering from nervousness, headaches, etc., supplies a want long felt by the profession, and should meet with their hearty support, as its advantages over the strong narcotics will be at once apparent to every physician.

CANADA

MEDICAL & SURGICAL JOURNAL

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Original Communications.

CASE OF ACUTE DIABETES MELLITUS.

By EDWIN GOODMAN, M.B., St. Catherines, Ont.

The following case of diabetes mellitus is of interest, in consequence of the extreme rapidity which marked its course from its inception to its fatal termination, and because it seems to throw a ray of light upon the etiology of the disease :—

The patient who forms the subject of this sketch, Miss R., of Port Dalhousie, was first noticed to be ailing on the 26th day of March last. I was consulted on the following Thursday, the 29th day of the same month. At that time I was informed by her mother that she had been suffering from a cold, in common with many others in the village, a sort of epidemic influenza having been very prevalent throughout the Niagara district during the month of March. No reference was made at this time to unusual thirst, to voracious appetite, or to excessive urination, although I subsequently discovered that the first and last symptoms manifested themselves on the 24th of March, five days before I saw the patient. The mother did not recognize their significance, and consequently made no allusion to them. The patient was said to be weak and languid, but anxious, nevertheless, to go to school to prepare for an approaching examination. General debility, languor, depression, and a feeling of *tiredness* were the symptoms I was asked to prescribe for. I gave a mixture containing citrate of iron and quinine, and Dobell's pancreatic emulsion, with rum and milk. The parents were advised

to keep the patient from school, to give all the food she could digest, and to encourage her to live out of doors as much as possible. In the event of no improvement taking place, the patient was to be brought to me in a week's time. My attention was not again called to the case until Friday, the 13th day of April last. On that day a lady friend and relative of Miss R. came in great haste and anxiety, and desired that I should go immediately to Port Dalhousie to see Miss R., who, she said, was much worse, and growing feebler and more emaciated every day. She informed me that the patient had come to her house on a visit, and had fainted away owing to her extreme weakness. She said that she had been put to bed; that her parents were alarmed at her condition; and that my immediate attendance was required. On inquiring why I had not been informed before, if the patient had been growing progressively weaker, I was informed that the unsettled state of the weather had prevented them from bringing her to St. Catherines. I saw the patient on the morning of the 13th of April, as requested, and was shocked at the change which had taken place since my last visit, two weeks before. She seemed literally to have *melted away*. In her normal condition she was always delicate-looking and slender; but I found her emaciated, hollow-eyed, and shrunken to the last degree. Her extremities were cold, her forehead rather warm, her pulse feeble, but not accelerated, her skin rough, dry, and "scurfy," her lips dry and parched, her tongue moist, covered with a brownish fur, and fissured. There was no pain or tenderness anywhere; nothing but extreme prostration. It flashed through my mind, the result, I suppose, of an almost unconscious chain of reasoning by exclusion, that I had a case of diabetes before me. I asked the patient's mother if her daughter had been passing much water lately? She said, "Yes, great quantities; she fills a chamber-vessel every night, and it is queer-looking." I asked her how long she had noticed this state of things? She said, "About two weeks." I asked her if she was very thirsty? She said, "Yes, she wants to be drinking water all the time." I asked her how long she observed the existence of this great thirst? She said, "Not longer than two

weeks." In answer to my enquiries both then and subsequently, the patient's parents and intimate friends have all said that nothing unusual had appeared to be the matter with the patient until she had the catarrhal attack two weeks before the 13th of April. But that when she contracted the cold, and ever afterwards, she seemed week, easily tired, despondent, and chilly. Aware of the rarity of such an exceedingly acute form of the affection, and thinking that possibly the disease might have existed for some time in a latent, or sub-acute stage, I carefully cross-examined her relations and intimate friends and associates, as well as herself, and in no case could I elicit any evidence of the existence of wasting disease, excessive thirst, or profuse and frequent urination, or even of unusual debility, until just before the case came under my notice on the 29th day of March last. The patient died on the 15th day of April last, just three weeks from the day the thirst and profuse urination made their appearance. The family history of the patient is good. Both father and mother appear to enjoy good health, and on neither side have there been cases of phthisis or diabetes. Grandparents, uncles and aunts, were all sound and robust. I am not aware of the existence of any syphilitic taint in either of the patient's progenitors; but, possibly, *pre-natal* malnutrition may have been occasioned by *chronic alcoholism* on the paternal side at the time of procreation. The patient had one brother and a sister, who died during infancy from an attack of *cholera infantum*. The patient's skin was always dry, harsh, and unperspiring; her appetite was excellent, but never inordinate; and she was always very fond of "sweets" and all kinds of starchy and saccharine food. She was quiet and studious in her habits, gentle and retiring in her manner, fond of her books, and indisposed to indulge in "romping" with her play-fellows. She had never suffered from sadness or "long sorrow," and had never received blows or shocks which might have excited irritation of the "saccharine centre" in the floor of the fourth ventricle. There was not sufficient time to develop the condition of the brain so graphically depicted by Dickinson in his admirable account of the obliteration of the

central blood-vessels,and enlargement of the peri-vascular spaces, as a cause of glycosuria. She was always surrounded with every comfort that kind and indulgent parents could provide for an only and beloved child. As before stated, I thoroughly satisfied myself, by evidence that seemed to me to be irrefutable, that the disease did not manifest itself until the 24th day of March. Up to that date, and until the morning of the 26th, two days afterwards, the patient was cheerful and possessed of her usual strength, and walked about, and enjoyed herself while visiting her friends in this city. On the 24th, however, the lady at whose house she was staying, noticed that she drank a great deal of water, and rallied her on the subject, asking her if she had not been eating something which made her thirsty. This lady, a very intelligent person, by the way, also noticed that she began to urinate frequently and profusely at about the same time, and that she had an excellent appetite, and a great craving for "sweets." On the morning of the 26th the patient returned to Port Dalhousie from St. Catherines, and on that day she contracted her cold, while riding the distance, four miles, in the stage-coach which plies between the two places. The "cold" may have been one of the factors *aggravating* the disease after its inception, but it was not the *exciting* cause, because the diabetic symptoms made their appearance before the catarrhal affection was contracted. I sought another clue to the causation of the malady. I asked the mother if her daughter, who was aged fourteen years and three months, had ever menstruated? She said, "No." I asked her if just before she went to St. Catherines, on the 24th of March, she had noticed any disturbance whatever in connection with the uterine functions? Any pain, any discharge? She said, "Yes, a day or two before her daughter went to St. Catherines, she complained of a *dull aching pain in her back*, of a *bearing down feeling*, *headache*, and *slight discharge of whites*." "But there was no appearance of blood." After the symptoms above alluded to had subsided, after this abortive attempt at menstruation, the glycosuric symptoms developed themselves. Was it a case of *propter hoc*, as well as *post hoc*? I

think it was. It must be borne in mind that Miss R—— had been going regularly to school, and was in her usual health up to the 24th of March, the day she visited her friends in this city, and that it was upon this *very day* she drank so much water, and passed so much urine, for *the first time*, and that the 24th was the day following the disappearance of the symptoms which it is fair to suppose marked an unsuccessful effort of nature to establish the catamenia. On the 29th of March, I prescribed for her as before stated. The attack was a slight one, and I am now convinced that the marked prostration of strength, which was out of all proportion to the severity of the catarrhal affection, was due to the impaired nutrition resulting from the glycosuric disease.

I say I am *now* convinced of it; I did not realize it *then*. Unfortunately, her mother did not herself attach any importance to the specific symptoms, and did not therefore call my attention to them. It was not until I saw the patient again, two weeks later, that the proper diagnosis revealed itself, as it were, through the prominence of the objective symptoms. It was too late to do any good *then*, even if treatment would have been of any avail at an *earlier period*—which may be doubted. I believe that the onset of the disease was due to an abortive attempt at menstruation, marked by the symptoms above referred to; and that reflex irritation was conveyed from the congested and unrelieved *ovaries* and *uterus*, through the ganglionic nerves supplying them, to the solar plexus, the semilunar ganglion, the splanchines, and the vaso motor nerves, and, indeed to the whole sympathetic system of nerves presiding over the functions of digestion, secretion, assimulation and circulation. If this condition had been recognized at first, before the morbid impression had become *fixed* and *titanic*, so to speak, *possibly* something might have been done. If the local congestion, the *fons et origo mali*, had been relieved by *local depletion* or by *general revulsives*, *arousing* and *diverting* the energies of the ganglionic nerves into other channels, the attack *might* have been frustrated and nervous equilibrium re-established. If such a case presented itself to my notice again I

should certainly apply leeches to the verge of the *anus*, the *vulva*, or the *os uteri*. I should give *Jaborandi*. Jaborandi I have found very efficacious in the treatment of the attacks of spasmodic asthma, in uterine tormina and tenesmus from ovarian neuralgia, in facial and cephalic neuralgia, in arresting the paroxyisms of ague in the first stage, and in senile psoriases and prurigo, vicarious of bronchitic asthma. Jaborandi certainly possesses marvelous power over the vaso-motor nerves, and if given in time, before morbid changes had been set up either in the ganglia first attacked or in those reflexly and secondarily affected, reasoning from analogy and on physiological grounds, much benefit might be expected to result from its administration. Guided by the clue afforded by the *vis medicatrix naturæ*, which induces a flux from the mucous membrane of the intestine, oftentimes, when menstruation is deficient or otherwise abnormal, a sharp aloetic purge at the critical period of the menstrual molimen might tide over the difficulty. So might the Turkish vapor or hot air bath. The hypodermic use of one or two of Wyeth's tablets of morphia and atropine, if the abortive menstrual effort was attended with pain, and the skin shrunken from contracted capillaries, due to irritation of the sympathetic vaso-motor centres, would prove extremely serviceable as a palliative, if not as a curative expedient. I have assumed that the disease is of nervous origin, or, at all events, that it is through the instrumentality of the organic nerves that its baneful influence is exerted. Frequently, no doubt, it is the *cerebral centre* of the sympathetic from whence the morbid agency radiates to the ganglia and plexuses whose functions are to preside over so many vital processes. One case occurred in my own practice, several years ago, in which the disease was certainly traumatic, and was occasioned by the patient falling a distance of twelve feet and alighting on his heels with his body erect. He felt a dull pain in region of the *ligamentum nuchæ*, and over the lower portion of the occipital bone. He immediately became diabetic, and died in three months. But admitting the frequency of the cerebral origin of the disease from injury and morbid emotions, and possibly

hereditary transmission, that does not by any means preclude the probability of the disease originating from morbid irritation of any of the sympathetic ganglia or plexuses. I have no doubt when attention is directed in that way, and not confined too closely to looking for a cerebral origin of the malady in all cases, that future observation will prove the correctness of the assumption that in the majority of cases of death from diabetes, occurring in females at the period of *puberty* and of the *menopause*, the exciting cause will be found to consist of morbid irritation of the ovarian and uterine ganglia and plexus of organic nerves. Bartholow, in his "Practice of Medicine," calls attention to the *post mortem* appearances present after death from diabetes. He speaks of the "atrophy of the pancreas" as of "great pathological importance," and attributes it to the "enlarged, thickened and almost cartilaginous hardness of the solar plexus, semi-lunar gangleons and splanchmines." Evidently from the numerous lesions produced by diabetes in those tissues, glands, organs and secretions, dependent upon the integrity of the sympathetic for their physical well-being and normal physiological action, morbid irritation of the ganglionic nerves must necessarily be the chief, if not the sole factor in the production of the disease, whether that irritation arises from traumatic, emotional or systemic causes. Are not Addison's disease and progressive pernicious anæmia closely allied to diabetes? Are they not all three fatal neuroses of the sympathetic system of nerves? I owe an apology to those who have followed me this far for not having condensed my matter into a smaller compass. Lack of time and a desire to impress the facts, as I viewed them, upon the minds of others must be my excuse for prolixity and tedious repetitions. The kind friend who is responsible for the paper must bear his space of odium for the infliction, if he possesses sufficient temerity to have it published without revision and curtailment.

N.B.—The urine of the patient contained a great quantity of grape sugar, and its specific gravity was 1038. Delirium supervened six hours and coma three hours before death.

CLINICAL REMARKS ON A CASE OF HODGKIN'S DISEASE.

(*With a cut.*)

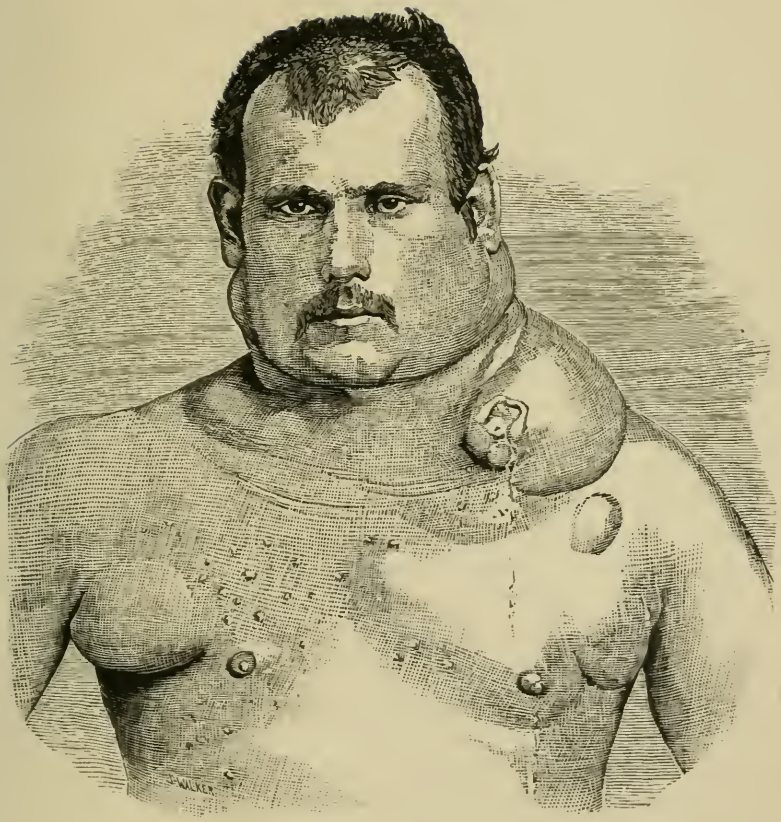
Summer Session, Medical Faculty McGill College.

By WM. OSLER, M.D., F.R.C.P., Lond.

Professor of the Institutes of Medicine in McGill University, and Physician to the Montreal General Hospital.

Gentlemen.—The patient before you is the subject of a remarkable disease which was brought to the notice of the profession in 1832, by the late Dr. Hodgkin of Guy's Hospital. Although others had previously described cases, and Dr. Hodgkin had not himself a very clear notion of the relations of the affection, still, his paper forms the starting of our present knowledge, and the majority of English writers have, since 1865, followed Dr. Wilks' suggestion and called the disease after his name. Synonyms of it are General Lymphadenoma or—adenosis, Pseudo-Leukæmia (Cohnheim), and Adénie (Trousseau). The disease is characterized by a progressive enlargement of the lymph glands in certain regions, and anæmia. There may be enlargement of the spleen, and occasionally there are localized growths of lymphoid tissue in different parts of the body. The colorless blood corpuscles are not usually increased. The report of the case is as follows: R— A—, from near Belleville, Ont., was admitted to Montreal General Hospital June 6th, suffering with enlarged glands. Patient is 34 years of age; married; no children. No record of any scrofulous or tuberculous affections in his family. Had jaundice four years ago; ague two years ago; nothing special about these attacks. Otherwise has been quite healthy until present illness set in.

A year and a half ago one of the glands of the neck began to swell and rapidly increased in size; three months later another one on same side of neck began to enlarge, and still later others became involved. Axillary glands and those of groin became affected six months later than the cervical, but not to the same extent. At times he has had epistaxis and blood-spitting, and he has lately had a troublesome cough.



On inspection, patient is seen to be a fairly well developed man, dark hair and eyes, not anæmic or cachectic looking. The skin is unusually dark, particularly on the back of the hands, is rough and covered with a pruriginous rash. The left arm and forearm are swollen, hand not œdematous. He presents a remarkable appearance from the enormous development of the cervical and axillary groups of lymph glands. From in front, the neck on the left side seems almost obliterated by a large mass which projects over the clavicle and towards the shoulder, and extends from behind the ear to the second interspace on the chest. On one spot there is a slough, and about it the tissues are reddened and inflamed. On the right side the cervical glands are not so much enlarged; the axillary groups form large bunches which project nearly to the nipples. Two isolated glands on the chest above the left nipple are considerable enlarged. The veins are not distended, but there is a good deal of subcutaneous infiltration over the sternum. Posteriorly, the breadth of the neck is very great on the left side from the enlargement of the deep glands. The individual glands in the axillæ and right cervical regions can be felt; but in the large mass in the left side they have more or less fused together, and in spots have involved the skin. To the touch they are soft, elastic and painless. The inguinal glands are moderately enlarged. The abdomen is full; veins not distended. Cardiac area of dulness a little increased; basic systolic murmur; nothing special in right lung; at apex of left, breathing is weak, but it is difficult to examine on account of the swellings in the vicinity. No difference in the respiratory sound at the bases.

Examination of throat and tonsils shows nothing special. No difficulty in swallowing; voice not specially altered, but he thinks he is a little hoarse. No history of any special pain about bowels. Bowels rather costive. Urine is slightly high-colored, acid, specific gravity, 1025; no albumen. Pulse, 90; temperature, 101°F. Liver and spleen normal. Opthalmoscopic examition of eyes negative. No hemorrhages; discs clear. On withdrawing a drop of blood, it is seen to be of a fairly good color, not watery; on examination the individual cells are seen

to be a little pale ; colorless corpuscles relatively increased ; many smaller than usual ; fibrin filaments very distinctly seen. Red cells regular in size. Hæmocytometer shows about 4½ million red cells to the cubic millimetre ; a proportion of 1 white to 150 red corpuscles.

The patient will now strip that you may see the extent of the glandular swellings ; rarely will you see them more pronounced. From behind the appearance is even more striking. Fortunately for him the large bunches on the left side have grown outwards and have not seriously involved the veins and there is no pressure on the trachea. The only interference with the circulation is by the growths in the left axilla. In this disease much depends on the group of glands involved. This patient tells us that he has had little or no pain and has only the inconvenience of these large tumors which impede the movements of head and arms. Very much less swelling of the internal glands may produce intolerable anguish from pressure on the nerves. I remember well the first case of the kind I saw. A large stout man, whose only symptoms were terrible pains in the back and legs and œdema of the feet. The retroperitoneal and pelvic glands alone were affected and pressure on the nerves produced the severe pains. When in the mediastinum the enlarged glands may compress the trachea or bronchi or the great vessels and bring about a most complicated series of symptoms. The case in No. 11 which interested us so much a few weeks ago—too much, in fact, as he got frightened and left the Hospital—was one of this sort. Extensive pleural effusion on the left side, group of enlarged glands above left clavicle and a large bunch of them in the abdomen. I have no doubt of the nature of the case, but the pleurisy was the most prominent feature, probably dependent on the pressure of mediastinal glands. I pass around the photographs of a case* in which the mediastinal glands were chiefly involved. Notice the great prominence of the sternum. You notice that the patient before you does not look anæmic, much less cachectic. He has been a robust, healthy fellow, and the calls

*Cases of Hodgkins Disease. CAN. MED. & SURG. JOUR., Feb., 1881.

upon his reserve fund, by the growth of these masses, have been so far well met, and though he has lost flesh, his nutrition is still fairly good. The blood count would seem to tell us this for the percentage of red corpuscles is not far off the normal, but there is a relative increase in the colorless cells and the density and size of the fibrin network which separates out between the rolls of red corpuscles indicate disturbance in hæmatosis.

The pigmentation of the skin is here doubtless due to involvement of the branches of the solar plexus in glandular tumors, though we cannot feel any through the thick abdominal walls. I have read reports of two or three instances of this bronzing in Hodgkin's disease. The patient is quite positive about the deepening of the color and we can scarcely attribute it to the prurigo caused by the papular rash which is on the trunk. Another point in this man's case is the pyrexia. As you see by this chart he has irregular fever, at times reaching as high as 102° F. In the majority of instances the temperature is raised and it may be a continuous pyrexia not as in this patient, remittent.

We know nothing as yet of the causation of the disease. So far as we can ascertain this man comes of healthy stock, and his personal history gives no clue to any morbid influence. Now that he has left the room we can discuss freely some other questions. The lymphatic tumours are due to an enormous increase in the cellular elements of the glands—a progressive hyperplasia. The consistence will depend on the amount of gland stroma; when abundant, the tumours are firm, when scanty, as in these, they are soft. You saw the day before yesterday a beautiful example of lymphoid growth, and as some of you were not at the autopsy, I will demonstrate the specimens again. I have here the right lung, bronchi and trachea, and you see these large tumours about the latter; there is general enlargement of the bronchial glands, and here at the root the tissue of the right lung is invaded. Section of one of these glands shows a soft white material which, under the microscope, is seen to consist of ordinary lymphoid cells, with but little stroma. In this case there was a secondary growth on the membranes of the cord, and a small one in the tail of the pancreas. Now what is the differ-

ence between these growths and the tumors you have just seen in R— A—? Little enough macroscopically, or microscopically, and yet there is a difference. I told you that the bronchial growths was primary lympo-sarcoma ; it is distinguished from the lymphoid growths of Hodgkin's disease and leukæmia by a more rapid development, a greater tendency to invade contiguous structures and when it generalizes, *i.e.*, from secondary tumors, they may be in any and every organ and not confined, as in leukæmic and pseudo-leukæmic growths to one or more organs. In this case, the secondary tumors were in the spinal membranes and pancreas. Sarcoma of the lymph glands is apt to early penetrate the capsule of the glands and invade neighboring parts. You see this in the lung here which has been involved. I have a specimen of sarcoma of the tracheal and bronchial glands which crept up and invaded the thyroid.

With lymphatic leukæmia, Hodgkin's disease has many similarities, so much so that the mere absence of one feature, *viz.*, the increase of colorless blood corpuscles, seems scarcely enough to justify their separation. And further there have been cases in which the leucocytosis, as exists, for example, in R— A—, has increased to a positive leukæmia and that within a very short time. The prognosis is as bad as can be. The enlargement is progressive, and though in the instance before us the groups involved have not as yet seriously interfered, either by pressure or otherwise, the gradual impairment of nutrition and the drain upon the system, by the suppuration which is likely to follow in the large mass, will induce asthenia, if pressure effects do not supervene and bring death more rapidly.

With such a prognosis you may judge of the value of treatment in these cases. An important point is, should the glands be excised? If in a localized group, as on one side of the neck, and there is no constitutional disturbances—yes ; but if several localities are affected and there is constitutional affection—no ; the results are decidedly against it. In addition to iron, general tonics and good diet, I give arsenic in increasing doses, begining with two or three drops three times a day, and increasing gradually, if the patient bears it, to twenty or thirty

drops daily. Under its use I saw the glands on one side of the neck get decidedly smaller, and I have under this treatment at present a lady whose general condition has much improved, and the gland swelling considerably diminished. Phosphorus has been found beneficial by some observers.

RAPID FORMATION OF BLOOD TUMOUR IN LEFT LABIUM MAJUS DURING LABOR—SPONTANEOUS RUPTURE—EXCESSIVE HÆMORRHAGE.

By THOMAS A. RODGER, M.D., Montreal.

This case being the first of the kind which has occurred in my practice, I venture to bring it to the notice of your readers, hoping that possibly it may prove instructive to some of them, as it has been to me.

M. A., aged 29 years, primipara; a strong, healthy, active woman, was taken with labour pains about four o'clock in the afternoon of the 17th of May last. I was requested to visit her at seven o'clock that same day, and on examination found the os uteri about the size of a ten cent piece, soft and easily dilatable. Nothing else was noticeable at this time in connection with the case, and everything passed on favorably until about eleven o'clock, when, noticing that the pains had increased very much in severity, taking on a genuine bearing down character, I was induced thereby to make a vaginal examination. I now found, for the first time, a swelling in the left labium, which at this stage of the labour was about the size of a pigeon's egg. I questioned the patient concerning the condition of the parts during her pregnancy, but was told that she had not noticed anything at all unusual, neither swelling of any sort whatever, not even in the veins of the legs. With each accession of pain this tumour was getting larger, until it reached the size of a small fœtal head, and finding that the head of the child was yet high up above the brim of the pelvis, I at once determined upon applying the forceps. My friend, Dr. Wood, very kindly came to my assistance, and was in the act of giving ether, when another severe pain came on, and notwithstanding that I was giving the swelling all the support possible with my

hand, it burst, permitting the escape of a large quantity of blood mixed with clots. There being yet pretty smart bleeding, it was agreed to hope for its arrest by the introduction of fine silver wire sutures, passing them deeply into the neighboring tissues, which had the desired effect. The patient in this case did well. Neither pulse nor temperature giving any indication of constitutional disturbance. It was necessary for the first few days to catheterize, and the vaginal douche was regularly kept up, using carbolized water of the strength of 1 to 40 at first, subsequently 1 to 60.

The explanation to be given for the foregoing occurrence must be the rupture of a varix in the vagina—yet no outward evidence of such a condition was known to the patient. Nor did I myself detect such a condition, notwithstanding that I had made several vaginal examinations previous to the first manifestation of the blood tumours. The rent took place on the inner side of the labium, and was about three inches in extent, running close down to the rectum, but not injuring the perineum proper. The bleeding being very profuse, I first tried to stay it somewhat by introducing a large sponge, which permitted of time to ascertain if there was any advance being made in the position of the child's head. Finding that the sponge was becoming very rapidly saturated with blood, I had it removed and an attempt made to secure, if possible, some of the ends of the large bleeding vessels. Torsion served to arrest the flow somewhat, but still from the bottom of this tear bleeding was very profuse, so I applied the forceps at once and delivered the child. The perineum escaped any tear in this instance, and no wonder when we consider the rent which was alongside—and which really presented a somewhat formidable sight—the opening and cavity being sufficient to admit and contain without difficulty the clenched fist.

So far as I have been able to ascertain, there are but few cases of this nature recorded, and in none have I met with it occurring during the progress. In the *British and Foreign Medico Chir. Review*, Vol. XXXVI, page 262, Dr. F. W. Helfer makes mention of a case of rupture of varix in the vagina after labour, causing death ; and in the New York *Journal of*

Medicine, Vol. V, page 317, Dr. William Thompson relates "a case of pregnancy complicated by varicose veins of the lower extremity and pudenda, followed by rupture of the left labium, and alarming hæmorrhage." In this latter case the labour did not occur until two weeks afterwards, and ended favorably.

I might just add, in conclusion, that I visited my patient yesterday, July 6th, found no varicosities of the perineal veins of either side; the rent has healed up entirely, and the patient feels well in every respect.

ABSTRACT OF CLINICAL LECTURE ON INFANTILE SUMMER DIARRHŒA.

Summer Session Medical Faculty McGill College.

By A. D. BLACKADER, B.A., M.D., M.R.C.S.
Lecturer on Diseases of Children, McGill College.

Gentlemen,—The advent of this summer heat will probably bring with it in its train numerous cases of infantile diarrhœa; and both at the Children's Dispensary and in the Out-patient Room of the Hospital, you will have full opportunity to study its clinical features. You will notice that, beginning with a few cases in the early weeks of June, the numbers will increase, slowly if the weather be cool, rapidly if the heat be more intense, to reach their height about the end of July and beginning of August; then to decline, till, in the cooler weather of September and October, the new cases cease altogether, and we have only those left in which the disease has taken a more chronic course. You will find how prevalent and how fatal this disease is in early life, for by far the larger number of the cases occur under the age of two years or two years and a half. Over this age the liability rapidly diminishes, so that in childhood proper, diarrhœa is not much more frequently met with than in adult life, and presents very similar clinical characteristics.

There are several reasons for this strong predisposition to this disease in infancy. One is to be found in the fact pointed out by Jacobi of New York, that in infancy there is a normal tendency to loose liquid evacuations. The food is more liquid;

the peristaltic movements of the bowel are more active; the young blood-vessels more permeable, and the peripheric nerves lie more superficially than in the adult, whose mucous membranes and submucous tissues have undergone thickening by both normal development and morbid processes. We have also a fact that I have before drawn your attention to, the peripheric ends of the nerves larger in proportion than they are in the adult, and the anterior horns of the spinal cord more developed than the posterior ones, so that we have greater reflex intestinal irritability to deal with.

Another reason lies in the fact that the age specially liable to this catarrhal action is the period during which the development of the minute intestinal crypts or follicles is going on. It is therefore a time when normally the afflux of blood to these parts is at a maximum; and even a slight amount of irritation may bring on congestive or inflammatory action.

As exciting causes, improper food and faulty digestion have much to do in the causation of this disease. Infancy is particularly liable to troubles of indigestion; partly because its nervous system is more susceptible of disturbing influences; but principally because it is so dependent on one source for its proper food, and all interferences with the functions of lactation in the mother affect her infant. In many cases it is deprived of it altogether, and faulty and indigestible food is supplied in its place. Not only does this interfere with proper assimilation, but especially in the infant does this undigested food act as an irritant, stimulating the already hyperæmic glands to excessive action. When large amounts of starchy foods in a not easily digested state are given, acid fermentation quickly sets in, and adds to the irritating nature of the alvine contents, producing even externally intense erythema of the buttocks. As a frequent cause co-operating in the production of this faulty state of the digestion, the habits too often permitted by mothers of allowing their infants to nurse too frequently during the day, and perhaps all the night; or when bottle fed, to allow the child to remain half the time sucking an empty nipple, cannot be too strongly condemned.

Another and most important exciting cause is the summer heat. All the other conditions may have been to some extent in operation before, and yet the infant, though not perhaps thriving, can scarcely be said to have been sick; but with the advance of the warm weather a relaxed state of the bowels sets in. In what way does this summer heat affect the infant? Probably in part directly lowering the tone of the nerve centers, especially when from other conditions these are already enfeebled, inducing relaxation of the vessels and favoring osmosis into the intestines; indirectly also by interfering with digestion, and thus favoring the passage into the intestines of undigested and acrid fermenting material.

Probably in all the earlier cases the heat has acted in this way. But another and most important effect produced by the heat is the contamination of the air, more or less, throughout all the neighborhood of large cities, but especially in their low-lying and crowded districts, with exhalations from decaying organic material. Exactly what is the specially obnoxious matter of this contamination, we do not know. Whether the effects produced be due to the imbibition of the gases evolved in the decomposition of organic matter, or, what is much more likely, to some low form of fungoid growth, is uncertain; but of the fact itself, experience on all sides teaches us, and such of you as may have attempted work in the dissecting room during the warmer days of spring may have had personal proof of it. In this connection we should remember that milk and all articles of infant diet readily absorb such matters from the air. It is well, therefore, always to have infant food cooked immediately before using. It should not be allowed to stand exposed to the air for some time, and then be simply warmed over.

As may be expected from a consideration of the various causes that may induce an attack, the commencing symptoms vary much in severity; occasionally the illness begins acutely with choleraic symptoms of vomiting and frequent purging; more frequently the onset is more insidious. Lassitude, slight fever, towards evening, and fretfulness with movement of the bowels several times a day, are symptoms which the mother

passes over as only temporary and of little moment. But they continue and increase in severity. Vomiting may or may not set in. This often seems to depend on increased acidity of the stomach ; at other times it is apparently more reflex in character. If appropriate treatment be not given, the diarrhœa increases ; if the inflammatory action predominates in the colon, much mucus, and occasionally streaks of blood, are passed. The pulse is considerably accelerated ; but the febrile reaction is seldom very high. Pain, and the sleeplessness and fretfulness induced by it, now become prominent symptoms. Wasting begins early, and symptoms of exhaustion soon set in. The urinary secretion is much diminished in amount. The skin becomes dry and harsh. If the disease is protracted, symptoms of spurious hydrocephalus set in, followed by drowsiness ; the stools becomes less frequent, and death occurs quietly. Occasionally towards the close a slight dry cough may disturb the child, and announce the presence of hypostatic pneumonia, although, by percussion, we may not be able to detect any definite dullness at the base of the lungs.

What is the lesion, gentlemen, of which these symptoms are but the expression ? Anatomically, it is a catarrh of the whole intestinal tract ; but especially affecting the lower part of the ileum and caput coli, in the neighborhood of the valve and the descending colon and sigmoid flexure. As Lewis Smith has pointed out, these are the places where the irritating fæcal matter is most apt to be delayed and to accumulate. On examination, we find the mucous membrane much more vascular and thickened over these portions. The glands, both the solitary and the agminated, all along this tract will be found swollen. Even in cases where the intestinal trouble has been but recent and slight, these are affected, with the follicles around them ; but where the inflammation has been severe and protracted, these go on to ulceration—the ulceration process commencing apparently in the follicles around the solitary glands.

With regard to the treatment, our first efforts should be directed to placing the infant under the best hygienic conditions possible. If a selection can be made, the coolest and airiest

room in the house should be chosen for the child's cot; if necessary removing woolen curtains, and such like, that may interfere with the free passage of fresh air through the apartment. The attendant should be impressed with the necessity there is for keeping the child quiet. No unnecessary movement of it being allowed. Should the child be strong enough, it should be taken out twice a day during the cooler hours of the morning and evening; preferably in its carriage to being carried in the arms, and all jolting in driving it should be avoided. When practicable frequent trips in the cooler and purer air over water are to be desired. The feeding of the infant is of the highest importance. If still nursed, strict injunctions as to the frequency with which nursing is to be allowed should be given. If the child is thirsty between times, as with diarrhœa going on and the excessive heat, it is sure to be, a little well boiled rice or barley water, or a few mouthfuls of cool filtered water may be given. If the mother's health be in any way at fault, measures should be taken to restore it. If the child be fed by the bottle, even stricter precautions are necessary. A little longer intervals should be allowed between the times of feeding, and the greatest watchfulness is necessary to ensure absolute sweetness and cleanliness about the feeding bottle itself. Great difficulty is often experienced in these cases to get a food that will agree well. Foods that during winter children thrive on and do well, in the summer season cause acidity and disagree. This is especially true of most of those patent preparations sold for children's food in the shops. After the trial of a good many, I still rely most, for young infants, on the receipt containing gelatine and arrowroot, given by Meigs & Pepper. And for older infants on a thin pap made from wheaten flour that has been boiled dry in a bag for twelve hours.

At the Infant's Home in this city I made careful trial in several cases of milk prepared with the pancreatic extract of Fairchild Bros. & Foster of New York; but was not altogether satisfied with the result, and some children object to its taste. Wheys prepared either by adding sherry wine or dilute hydrochloric to milk are often of service when the milk is rejected curded.

As regards medicinal treatment, should the attack be recent, or we have reason to suppose some specially irritating ingesta still remain in the bowel, some gentle laxative should be given; and probably the best is either a small dose of castor oil, in an emulsion of gumarabic, with an opiate, or a small powder of soda and rhubarb. Otherwise, it seems better to commence at once with a sedative and astringent; and for this purpose, nothing seems to answer better than a combination of opium with bismuth. Both must be given in sufficient doses. For a child a year old, half to one drop of tincture of opium with ten or twelve grains of bismuth in an emulsion may be given every three or four hours, or oftener if necessary. If there is much acidity either of the stomach or dejections, a little chalk, as in the officinal Mist. Cretæ, may be added. Occasionally we have a great deal of general nervous excitement associated with the earlier stages of an attack. In such cases, Potassium Bromide or Sodium Bromide may be added, one or two grains to each dose. If we have reason to suppose, from the frothy character of the dejections, much fermentation is going on, carbolic acid in $\frac{1}{16}$ to $\frac{1}{12}$ drop doses may be added to the mixture of bismuth and opium. Where there is much mucus and slime, with streaks of blood in the motions, small doses of Hydrargyrum Perchloride, $\frac{1}{100}$ to $\frac{1}{80}$ gr., as recommended by Ringer, has often proved very efficacious in removing these conditions and improving much the general condition. For the troublesome and incessant vomiting, associated sometimes with frequent serous dejections, powders of $\frac{1}{6}$ gr. Hydrarg. with Cretæ, or $\frac{1}{2}$ gr. Calomelanos, rubbed up with a little sugar, and given hourly dry on the tongue, will often check the vomiting and alter and improve the character of the dejections. In many cases all our resources will be required to check the inflammation. When necessary, injections containing two or four minims of laudanum, in two drachms of starch water, thrown up directly after the bowels have been moved, and repeated as may be required, give great ease. Poultices in warm weather are, I think, to be avoided; but cloths wrung out of spirits and water, with some laudanum sprinkled on their surface, and applied over the abdomen and then covered with oiled silk, have, I think, proved of much service.

NOTES OF AN AFTERNOON WITH MR. JONATHAN HUTCHINSON.

By R. J. B. HOWARD, B.A., M.D., M.R.C.S.

1.—A boy of 19, well built, well nourished, muscular. No serious illness for past ten years. For three years has had epistaxis every three or four weeks; bled persistently after drawing of teeth on two occasions. Admitted very anæmic, with many petechiæ on limbs and abdomen; gums almost white, not swollen; no œdema anywhere; retinæ pale. Has had a good appetite, and good supply of food of all kinds. Not subject to constipation. Mr. H. pointed out that this was a case of true "Purpura hæmorrhagica," distinguished from "Purpura thrombotica" by the small round spots of extravasation; in the thrombotic form the spots are apt to be larger, and are always irregular; while owing to the way in which the discoloration extends along the vessels the term "seaweedy" is used as fairly descriptive. In this case there are none of the large "bruised" spots, swollen, bleeding gums, or other characteristic signs of scurvy; and moreover this lad has had no insufficiency of diet. Here no cause can be discovered for the disease, except possibly some family tendency, for his maternal uncles are said to have been "thin-skinned" and bleeding readily. This illustrates (if correct) the well-known peculiarity by which disease is transmitted through a family for generations, but only evidencing itself in the male off-spring.

2—*Case of Amputation in Lower part of Thigh, for Compound Fracture of Leg.*—In regard to this, after speaking of the man's state previously, Mr. H. said, that he thought we should never amputate in such cases as long as active inflammation was going on. Here an attempt was made to save the limb (Lister's dressing being used); but suppuration set in profusely, and it soon was evident that amputation must be done. But Mr. H. waited six weeks, after forming this opinion, till the man's temperature came down toward normal, and the suppuration seemed less active; he then amputated, with a good result. Only the occurrence of gangrene or septicæmia should warrant amputation during the time of active suppuration.

3.—In commenting on an ordinary case of suppurating bubo, Mr. H. said that the proper treatment was, in his opinion, to lay open the bubo freely and scrape away all the inflammatory matter which was to be found; and remove any neighboring glands that threatened to suppurate. If we made a small puncture or even a wide opening, and then drained, it took a long time for all the inflammatory tissue to come away; but by the plan he recommended, with the use of iodoform well packed in, the case would probably be cured in a few weeks.

4.—A woman met with a severe crush of the hand, for which amputation in the middle of the forearm was needed. Though done with Listerian precautions, suppuration occurred, the stump becoming swollen, painful and tense, and of a dusky red color. Mr. H. ordered several stitches (not all—about one-fourth) to be removed, and the wound to be dressed with evaporating spirit lotion. He pointed out that Lister's dressing, which was preventive only, had here failed of its purpose; and considered it was now the proper course to combat the inflammation. In dealing with an inflamed stump, such as this, he would use either a cold lotion or a poultice. The spirit lotion, if exposed, would form a cold lotion; if covered with oil-silk and wrapped up would form a "spirit poultice." In any case we had the antiseptic action of the spirit, and the anti-inflammatory action of cold, or the heat which would hasten the process to an end. In these cases Mr. Savory would at once apply a poultice; Mr. H. preferred the "spirit poultice."

5.—Speaking of the management of obstinate persistant epistaxis, Mr. H. said: "I have on several occasions had to treat cases of epistaxis, which had resisted everything that was tried; and I have always succeeded in arresting the bleeding without having recourse to plugging the nares." After condemning this procedure (plugging) as unnecessary, and even dangerous, and saying that he had once seen Tetanus result from it, he said that the proper plan of treatment is to make the patient set up in a chair, with his feet in hot water; that in the worst cases he had ever dealt with he had presevered in this for (I think) two days, and with ultimate success. The

object is of course to withdraw blood from the head by causing dilatation of arterioles of the lower extremities, and aiding the influx of blood by the force of gravity. He pointed this method out as specially valuable in cases of epistaxis occurring in people of an apoplectic habit. The patient should be kept upright, and not allowed to stoop till all hæmorrhage has ceased.

6.—On Dec. 21st, 1882, I saw Mr. H. amputate at the hip-joint by Furneaux-Jordan's method. I noted at the time: "Boy of 10; much wasted and very anæmic; twelve months before got periostitis of tibia: suppurated; extended into knee-joint; improved a little and was sent to sea-side; came back with extensive necrosis of femur, the suppuration having spread up the shaft nearly as high as the trochanters; one sinus opens in fold of nates. Liver reaches below umbilicus; spleen also enlarged; believed to be lardaceous. The object is—to remove *all* suppuration and thus give him a chance of recovery from his lardaceous disease. (N.B.—Trace of albumen in urine.)" This is a copy of my note, and a more unfavorable case I can hardly picture. To-day I saw the patient returned from a three months stay at the sea side. He had grown taller; was plump, a healthy color, much browned by wind and sun, and as jolly as a sand-boy. The stump was a capital one; and, best of all, his liver has lessened in size, though still enlarged (reaching midway between right costal cartilages and xiphoid), while his urine has been natural for a month past. This seems to me a remarkable result, and one which may teach a valuable lesson. I should like, Mr. Editor, to hear your comments upon it; Mr. H. seems to think that in children lardaceous disease is not so formidable as it is held to be.

7.—A girl had been admitted with an inflamed chancre of the labium minus. After speaking of the difficulty of distinguishing the infecting from the non-infecting chancre in women, and also of the proneness of chancres to become phagedænic in the young, he said that in this case the sore had lasted more than two weeks; and as he could not decide upon its exact nature, the proper course is to treat it locally and wait. In iodoform we had a therapeutic agent, which seems to exercise

a specific power in checking suppuration and encouraging healing; but it will not prevent the characteristic induration if the sore was really an infecting one. It is wrong to give mercury at once, as we shall then surely prevent induration, and so be unable to decide whether the patient should take mercury for six months or only for a few weeks.

REMINISCENCES OF DR. JOHN STEPHENSON, ONE OF THE FOUNDERS OF McGILL MEDICAL FACULTY.

By WM. WHITEFORD, Esq., of the Middle Temple.

[The following sketch of the life of one of the pioneer practitioners of this city is well worthy of a place in our pages, and will no doubt be read with interest by all citizens of Montreal and friends of the University, whose early days Dr. Stephenson so carefully watched over.—Ed.]

Dr. John Stephenson (my mother's brother) was born in St. Paul Street, Montreal, about 1794, and was the youngest of the five sons of Mr. John Stephenson, a merchant from Scotland, who began business in Canada the year after the conquest of Quebec—his family being one of the three first English-speaking families who settled in Montreal. Old Mr. Stephenson set up a tobacco mill and a brewery, the latter of which was sold at his death to Messrs. Dunn & Dow, and has developed into the huge establishment now called "Dow's Brewery." Four of the doctor's brothers, and his two brothers-in-law (James and William Whiteford, merchants), were "*out*" in the American war of 1812. Dr. Stephenson's education began at "Le College de Montréal," where his diligence and love of study attracted the attention and conciliated the regard of the Rev. Fathers, the Professors, evidences of which he continued to receive from the order of St. Sulpice until his death. The Rev. Mons. Leroux, Superior at the Seminary, through his brother, Dr. Leroux—a very eminent anatomist in Paris,—procured for young Stephenson admission to the best literary and scientific society in that city; and on his return from Europe, he, though a very young man, and a Protestant, had the honor to be appointed physician to the Order of St. Sulpice.

From "Le College de Montréal" he proceeded to Edinburgh University, where he graduated in Arts, as he did afterwards in Medicine (M.D.), having also become meanwhile a member of the London Royal College of Surgeons, and received some degree in Paris. His diplomas, together with all his papers, professional MSS., and correspondence, which were once in my hands, and might have been useful now, unfortunately perished at my office in the great fire at Montreal.

Two of his mother's brothers in London—James and Hugh Mair—were married to daughters of Sir Francis Baring, and possessed great influence, which they were willing to exert in his favor if he would establish himself in England; but as the relations between his uncle and his father were not very cordial, and as the latter, who was very fond of him, was in failing health, and desolate through his wife's death, the young doctor yielded to a sense of duty and returned to his native land. He arrived in Montreal after a four months voyage, only to find his father dead, and to find how difficult his long residence in Europe made it for him to reconcile himself to his old surroundings.

So much did he feel the absence in those days of that literary and scientific culture and society which had become almost necessary to him, and the absolute dearth then existing of educational establishments for the English-speaking portion of the community, that he resolved to do what in him lay to secure these for his countrymen, and devoted himself, from the first year of his return, to procure them that advantage (which was less important to him, as being as much French as English, especially to his own profession). Dr. S. was the first to begin the agitation which resulted finally in wresting from the hands of the heirs of Mr. Jas. McGill the bequest of that gentleman towards a college, which had well-nigh lapsed by the effluxion of time. Except from his own profession, he received but little sympathy at first, but soon he enlisted the support of his old schoolmate, Dr. Holmes, and then of his warm friends, Drs. Robertson and Caldwell, who, becoming professors with him, constituted the "McGill College" (Dr. S. himself filling the chairs of Anatomy and Midwifery), and began to confer degrees as McGill College long before it

had a "local habitation," beyond a certain house in "Little St. James Street, in which they opened lecture and dissecting-rooms, and which, until they received powers from Parliament, they called 'The Medical Institution,' or some such name." The name of the first undisputed graduate of McGill College was, I think, a Dr. Logie.

Inter al.—I know he took interest in the Natural History Society, and a great interest in the Montreal General Hospital; but his darling object was the McGill College, and I can remember now the anxiety and watchful energy with which he watched its infancy and early youth, devoting it time and thought probably to the detriment of his private practice. Among the steps which I remember his taking was the canvassing and procuring the nomination of a Colonial Board of the Royal Institution for the Advancement of Learning, the Hon. George Moffatt and Dr. Cook of Quebec being of the number. In the name of this body, promoting the suits against the McGill heirs (Desrivieres), and in their name procuring a charter or other empowering statute from Parliament. Indeed I remember his drafting a bill which was to be introduced by Mr. Simpson, M.P.P. for Cotean du Lac. He was glad to work, without much caring who got the credit, if only a good object was attained; and I well remember that in some private letters of introduction which the Hon. Peter McGill gave me when I came to London, he refers to my relationship to my uncle, whom he describes as "*the* man of all others to whom we owe the existence of McGill College."

Dr. Stephenson died about 1843—(I have a shocking memory for dates)—of, I believe, lung disease; his wife, a daughter of Mr. Thos. Torrance, an old resident, died about 15 years later. Their only surviving child is Mr. John Stephenson, M.A., Im. Coll. Com., at one time Professor of Astronomy and acting Principal in the Government University of Calcutta, and now of the Government Department of Education at Whitehall.

Dr. S. never practised elsewhere than at Montreal, and there must surely be some still living there who can remember his popularity with his patients and his neighbors of both nationalities, and the general considerateness and kindliness of his nature.

Some, too, there may be who can testify to the wideness of his culture, his love of the classics, of his linguistic attainments, German and Italian, quite apart from his knowledge of his own profession, of which he was so fond, and to whose interests and objects he was so devoted. I recall one of his injunctions to young graduates, "not to consider their studies concluded on the attainment of their degree, but rather beginning with actual practice, and continuing during the whole course of their lives."

I have referred elsewhere to the friendship which subsisted through life between Dr. Stephenson and his old playfellow—subsequent fellow-worker—Dr. Holmes, the first Dean of the Medical Faculty at McGill College, and a most earnest Christian, and I ought not to omit to mention his constant and untiring ministrations to his friend, especially in spiritual matters, to the great consolation of the dying man.

The pressure of time for post, and a failing memory, compel me to close this imperfect sketch of the life of a man who exercised a great influence on my life, unless I add that he was a man of singular force of character, generosity and enthusiasm, and though slightly brusque and eccentric in manner, tender-hearted to a degree. As regards myself, his personality, after the lapse of forty years, is as vivid as ever, and I feel yet the impulse he gave to my mind and character.

Reviews and Notices of Books.

A Manual of Auscultation and Percussion, Embracing the Physical Diagnosis of Diseases of the Lungs and Heart, and of Thoracic Aneurism.—By Austin Flint, M.D., Professor of the Principles and Practice of Medicine, and of Clinical Medicine in the Bellevue Hospital Medical College, etc., etc. Third Edition, Revised. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Bros.

Amongst all the many works now appearing upon the subject of physical diagnosis, that of Austin Flint upon Auscultation and Percussion, deservedly continues to hold its place. Its explanations of the various physical signs are based upon much thought

and observation. Every attempt is made to simplify the study of this—to many—somewhat intricate subject. No better manual can be put into a student's hands.

Hand-book of the Diagnosis and Treatment of Diseases of the Throat, Nose and Naso-Pharynx.—By Carl Seiler, M.D., Lecturer on Laryngoscopy at the University of Pennsylvania, Chief of the Throat Dispensary at the University Hospital, etc., etc. Second Edition. Thoroughly revised and greatly enlarged. With seventy-seven illustrations. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Bros.

Dr. Seiler's treatise on the throat is, we believe, already well known in this country. On comparing the present with the first edition, it will be observed that it has been extended in nearly all its chapters. It contains all the essentials of knowledge of these important localities, compressed into a small space, and put together by a clear writer who is, at the same time, one of the ablest of the American specialists. To students and others this handbook can be recommended as one of the best and most generally useful.

The Temperance Lesson Book. A Series of Short Lessons on Alcohol and its Action on the Body.—By Benjamin Ward Richardson, M.A., M.D., LL.D., F.R.S., Honorary Physician to the Royal Literary Fund, and Author of the Cantor Lectures on Alcohol. Thirty-eighth Thousand. London: National Temperance Publication Depot.

A small volume of lessons on alcohol and alcoholic liquors from a total abstinence point of view. They are intended for reading in schools and families. It is divided into fifty-two lessons, each of which takes up and elucidates some point concerning the physiological action of alcohol, its various abuses, its relation to food properly so called, etc. At the end of each are appended a short series of questions upon the preceding text.

Hand-book of Medical Electricity; with a Discription of a New Medical Battery.—By A. M. Rosebrugh, M.D., Surgeon to the Toronto Eye and Ear Dispensary, Member of the International Ophthalmological and Otological Societies, Toronto.

This is a small book, in paper, of pocket size, containing short directions for the application of galvanic and faradic currents in various diseases. It also contains a description of some modifications introduced by the author into the McIntosh Battery.

Medical Diagnosis: A Manual of Clinical Methods.—By I. Graham Brown, M.D. Edinburgh: Bell & Bradfute. Toronto: Carswell & Co.; pp. 351.

This is an excellent clinical manual, and will compare favorably with those in common use in the schools. It is concisely written, and the arrangement of chapters, particularly good. The student who is fortunate enough to study it, and at the same time have practical illustrations at the bed side, will have a thorough foundation in the difficult science of diagnosis. We commend the work to both students and teachers.

Books and Pamphlets Received.

Therapeutic Handbook of the United States Pharmacopœia: Being a condensed statement of the physiological and toxic action, medicinal value, methods of administration, and doses of the drugs and preparations in the latest edition of the United States Pharmacopœia, with some remarks on unofficinal preparations. By Robert T. Edes, C.B., M.D. New York: Wm. Wood & Co.

The Microscope and its Revelations By William B. Carpenter, C.B., M.D., LL.D., &c. Sixth edition. Vol. I. New York: Wm. Wood & Co.

The Diseases of Women: A Manual for Physicians and Students. By Heinrich Fritsch, M.D. Translated by Isidor Furst. New York: William Wood & Co.

Manuel des Injections sons-cutanées. Par Bourneville et Bricon, Paris.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, April 27th, 1883.

[Continued from page 688.]

Puerperal Eclampsia.—Dr. Armstrong read a paper on this subject, reporting three cases. In the first case, a multipara, a

fortnight before her delivery complained of the three symptoms regarded by Chaussier as premonitory indications of eclampsia, viz., cephalalgia, disorder of vision, and epigastric pain, together with œdema of feet, ankles and hands, with puffiness of eyelids. Although diuretics and occasional purges were given, a convulsion came on soon after labor began. Chloral Hydrat. was given every hour in doses of ℈i. After three or four doses the woman had a second convulsion, when chloroform was administered, and the first stage of labor being completed, the forceps were applied and the child delivered. The hæmorrhage following the birth of the child was considerable, requiring to control it a good deal of kneading of the uterus, and the application of ice to the cervix. The child was still-born, but the mother made a good recovery. In the second case, primipara, the convulsions first appeared a few minutes after the completion of a normal labor lasting fourteen hours. The comatose condition, which obtained after the first convulsion, persisted and deepened in spite of treatment, and the patient died sixty-four hours after she was delivered. No paralysis of face or other parts could be made out. The urine was highly albuminous. At the autopsy extravasated blood was found covering the superior surface of the brain, and dipping down in the sulci. Also a large clot, which measured four centimeters by four centimeters, was found in the substance of the left middle lobe of the cerebrum. It was situated in the parietal section of Pitres. The kidneys, microscopically, were found to be granular, and the veins were dilated. This dilatation of veins was found, in microscopic sections, of different tissue by Dr. Wilkins, who kindly examined them. The third case is of interest principally from the fact that gestation went on twenty-two days after the occurrence of two well marked convulsions. Labor then came on, and she was delivered of a living healthy child, without any recurrence of eclampsia. During the three weeks interval between the eclamptic seizure and delivery, chloral in ℈i doses was administered per rectum, as soon as any twitching of the muscles of the arms or disorder of vision with headache and epigastric pain appeared. This case shows how we can carry on

a case until the completion of gestation, by careful watching, appropriate treatment, even after two puerperal convulsions have occurred. The fate of the children in the first and third cases favors the idea that the death of the child is due to carbonic acid poisoning, it in its turn being due to the interference with respiration of the mother during the convulsive seizures rather than the toxæmic state of the mother's blood.

Dr. Armstrong stated that the digitaline used was prepared by Parke, Davis & Co. of Detroit. He thought the dose of gr. ¼ not too large. In reply to Dr. Wilkins he thought that if the condition of the mother's blood killed the child, then the child in the third case should have died, for in this case for three weeks before the birth of the child the mother presented symptoms of profound uræmic poisoning. Her urine never containing less than 30 per cent. of albumen. But the child was born alive and well. The only time the fœtal heart was weak, was the day of the eclamptic seizures. The fœtal heart sounds being stronger the next succeeding day.

Drs. Alloway and Cameron having raised the question of etiology, Dr. Armstrong stated that his impression was that puerperal eclampsia had a predisposing and an exciting cause. The predisposing cause might be, according to the theory of Dr. Barnes, an excessive nervous development, and an increased development of the spinal cord; or, according to the Traube-Rosenstein theory, increased aortic tension, followed successively by œdema of the brain, compression of the cerebral vessels, and acute cerebral anæmia; or the theory supported by Andral and Gavarret, that the blood of all pregnant women was hydræmic; or the theory of Kussmaul and Linner, of cerebral anæmia; or the theory of Braun that uræmic poisoning, due to Bright's disease of the kidneys, was the cause. Frerichs attempted to prove that the poison was due to ammonia carb., formed by the decomposition of the urea. Spiegelberg suggested that a reflex contraction of the vessels might cut off the blood supply to the kidneys, due to a peripheral stimulus. And Frankenhauser has demonstrated a direct connection between the ganglia of the kidneys and the nerves of the uterus through the sympathetic.

Or the predisposing cause might be any toxæmia or leukæmia. Probably all these theories apply in certain cases, but the exciting cause seemed to be some peripheral irritation, as held by Ohr and others.

Dr. Armstrong thoroughly believed in venesection where there was a distended right heart, and also in cases of high arterial tension, with a hard incompressible pulse, though the surface might be pale. Broadbent had proved venesection to be of the greatest value in this last class of cases. The use of large doses of morphia was undoubtedly useful in selected cases. But he had found bromide and chloral give very satisfactory results as a rule. In regard to chloral killing the child, there was no evidence to show that such ever was the case. On the contrary, chloral was often freely given in tedious prolonged first stages of labor without any injurious effect whatever upon the child.

Dr. Wilkins advocated inducing premature labor in cases where the convulsions appeared to be from uræmia or retention of whatever salt it is which poisons the mother, as he believed it poisoned the child also.

Dr. Alloway remarked that the etiology of puerperal eclampsia was interesting, from the different views entertained by eminent writers. He thought the theory of Lever—reported in the Guy's Hospital Reports of 1842—was the one generally accepted at present. Lever had shown that the urine in eclampsia was always highly albuminous, and that pathological changes in the kidneys, corresponding with those of Bright's disease, were frequently discovered. From these facts he contended that eclampsia was caused by the retention in the blood of urea and other constituents of the urine which it was the duty of the kidneys to excrete. The chief objection urged against the acceptance of this theory of uræmic intoxication was, that there were patients suffering from chronic Bright's disease who were not attacked with convulsions during pregnancy or parturition. This objection was, however, easily met by the explanation, that if this chronic disease be of long standing, the remaining healthy parts of the kidney will still secrete sufficient urine to prevent poisoning, and that eclampsia depended upon uræmic poisoning in consequence of

deficient or total suppression of renal secretion. Dr. Alloway also spoke of the well-known Traube-Rosenstein theory, which claims that eclampsia appears when the arterial blood pressure in a highly hydræmic subject is suddenly increased. In this case acute œdema of the brain is produced, the exudations of serum causing anæmia by compressing the blood vessels. If this condition was confined to the hemispheres it was thought coma would be produced, and if it extended to the motor centres we would get convulsions. The principal objections to this theory were, however, that many young, healthy robust women became eclamptic, and that many hydræmic patients enjoyed an immunity from convulsions. Dr. A. spoke of another class of cases in which the albuminuria is absent during the entire duration of the disease, or only shows itself in very minute quantity for a very short period. Such cases had been called "eclamptiform attacks," caused by reflex irritations of vaso-motor and spasmodic nerve centres by a peripheral excitation. According to Brown-Sequard the sciatic nerve plays a most important part in the production of these artificially excited epileptic attacks. Cases have been reported where an over-distended bladder in protracted labor had caused convulsive attacks; also a retained placenta has been accused of being the probable cause. Dr. Alloway drew attention to the recent treatment of puerperal eclampsia by very large doses of morphia, Dr. Clark, of Oswego, being, he believed, the first to practice it. In Dr. Clark's article in the *American Obst. Journal* of July, 1880, upon this subject, he recommended gr iss and gr ii doses to be administered hypodermically, and repeated on occurrence of another fit. Clark also states elsewhere that it would be absolutely safe to give as high as three grains in same way. Dr. Alloway had used over grain doses in two cases in association with Dr. Rodger with very gratifying results. He had also used pilocarpine, but was not much impressed with it.

Dr. Rodger said he had seen quite a number of cases of puerperal eclampsia, and believed venesection, combined with the hypodermic use of morphia, to be the best treatment. He had been disappointed with chloroform and chloral in these cases.

Dr. Trenholme said the second case reported by Dr. Armstrong possessed some features of special interest. It showed that convulsions in the mother did not destroy the life of the unborn child. It was a question in his mind if the death of a child in the uterus was not generally due to detachment of the placenta, caused by the spasms of the uterus, rather than a vitiated state of the mother's blood. In rare cases it might be otherwise. As to treatment—this would vary with each case—no definite rule could be followed. If the woman was plethoric and strong, blood should be promptly and largely abstracted; and then followed by a large dose of morphia, or bromide of potass. and chloral. In all cases chloroform was invaluable, and in some cases enough of itself. Where bleeding was not indicated, morphia in even gr. ii doses was good in its result. As to hastening delivery this would depend upon the results of the uterine contractions—if they caused the convulsive spasms, it was clearly our duty to empty the uterus, and set it at rest. If otherwise, wait for natural delivery.

Dr. Roddick believed he had several times used chloral with benefit. Has bled, but would only do so in suitable cases, such as those indicated by Dr. Trenholme. He said that Dr. Fuller, about eight or ten years ago, was the first to advocate the use of morphia hypodermically in puerperal convulsions; most of the members of the Society opposed him strongly on theoretical grounds. He, (Dr. Roddick) on this occasion, being one of those to denounce Dr. Fuller's treatment. Now he was convinced of the usefulness of morphia hypodermically used in these cases.

Dr. Stephen had lately seen chloral in large doses combined with inhalation of chloroform act well. He advocated using the chloral when premonitory symptoms appear.

Dr. Cameron said that although the majority of these cases are renal in origin, yet convulsions frequently occur where careful examination fails to detect any appreciable signs of renal disease. Sometimes profound anæmia, sudden shocks or frights, or an over-excited condition of the nervous system, seem to precipitate the attack. He detailed a case where convulsions occurred in a nervous, hysterical patient, profoundly anæmic, after

a severe attack of diphtheria; no symptoms of renal mischief being found either before or after confinement. He did not agree altogether with those who advocate the induction of premature labor, or the rapid completion of delivery by forceps or turning, when a convulsion occurs before the birth of the child. In many cases such practice does more harm than good, causing still greater irritation, and intensifying the convulsive action. Where the os is well dilated, or at least soft and dilatable, operative interference may be permissible; but where the os is hard, rigid and undilated, it is better to control the convulsions and wait till the parts are in a more favorable condition. With regard to treatment, he believed that while venesection is applicable to the robust and plethoric, especially where renal mischief exists, many patients can ill afford to lose blood. Where venesection is practiced, there is greater tendency to subsequent absorption of septic matters. He considered the best treatment for the majority of cases to be morphia, in sufficient quantities to control the the convulsions (the heroic doses advocated by some being usually unnecessary), followed by chloral and potass. bromid.

Dr. Wood had recently used venesection, but his patient was afterwards troubled with anæmia which caused her to lose her milk.

Dr. Osler said that in Dr. Armstrong's second case death was due to extravasation in the brain, and that this was a cause of convulsions sometimes.

Dr. Kennedy had seen a good many cases of puerperal convulsions, in all of which uterine contractions existed, and were the immediate cause of a spasm. The os was in all cases dilatable. Had used and found useful chloroform, chloral, bromide of potassium, and hypodermics of morphia in large doses. Believed venesection valuable prior to delivery of the child. As a means of blood-letting he encouraged the flow at delivery by giving chloroform and afterwards ergot to ensure good contraction and so stop loss. He agreed with Dr. Trenholme that the death of the child was due to separation of placenta by the spasmodic contraction of the uterus. Had delivered epileptics without their having convulsions.

Dr. Campbell related a case where convulsions came on between the 7th and 8th month; he bled, and the spasms ceased until end of ninth month, when they returned; he now applied forceps and delivered safely. Had confined her several times since without any trouble.

Stated Meeting, May 11th, 1883.

The President, Dr. Kennedy, in the Chair.

Chronic Papular Skin Eruption.—Dr. Gurd exhibited a boy, aged 10 years, suffering from this disease, most marked about the wrists and knuckles. The boy was one of a family of five, all of whom are affected, the servant alone remaining free. All suffer great itchiness at night after getting to bed. Treatment appeared to be useless. Many of the members thought it to be itch. Dr. Gurd brought the case for diagnosis, but did not think it to be itch, as no furrows were present, and the progress of the disease was not like scabies.

Muscular Atrophy.—Dr. Wilkins brought before the Society a man, aged 21 years, who was under his care in the Montreal General Hospital, affected with muscular atrophy, limited to the upper arms and thighs. The muscles of the forearms and leg are well developed, and presented a remarkable contrast to the wasted appearance of upper arms and thighs. There are no disturbances of sensation, but with the wasted appearance is associated more or less complete loss of power in the affected muscles. Patient was able to walk by a sort of shuffling movement; could mount the stairs, but only with assistance, and when kneeling or seated on the floor can rise only by grasping some support such as a chair, to aid his legs by the use of hands and arms. In this condition his one elbow (the right) must be raised above shoulders; the left elbow being held firmly on left knee. Patellar tendon reflexes are absent. The plantar reflexes are diminished. Faradic excitability is absent in muscles of thigh and front portion of upper arm. No bladder disturbance; no muscular tremors; nor does he complain of pain. Patient refers his trouble to a fall which he had about three

years ago. He fell on his buttocks from a height of ten feet, after which time he noticed himself gradually becoming weaker. About a year subsequently he had another fall while carrying a heavy weight on his head. The lesion Dr. Wilkins considered to be strictly limited to the anterior cornua of the grey matter, and to only a few groups of ganglion cells, and histologically to be exactly the same as those in *anterior-poliomyelitis* of children. The course of the disease and the grouping of the muscles affected, however, he considered presented no similarity to that affection; nor did he feel inclined to associate it with *progressive muscular atrophy* owing to the absence of tremors and the perfect development of all the muscles of legs and feet and forearms and hands.

Pernicious Anæmia.—Dr. Osler exhibited the spleen and bone-marrow from a patient who died in Hospital. She was 60 years of age, profoundly anæmic, with lemon-colored skin. Examination of blood during life showed irregular ovoid and balloon shaped red corpuscles; also many microcytes. No Schultze's granules. P.M.—The microscope revealed the marrow to be rich in lymphoid cells—that from the vertebræ had abundant red corpuscles, nucleated red blood corpuscles and also microcytes. Spleen which was not enlarged had an extraordinary number of microcytes, the mode of origin of which was probably by buds from ordinary cells. Dr. Osler had watched this take place in three cases of this disease. There was atheromatous disease of lower abdominal aorta, the bifurcation was bony and ulcers were found in the right common iliac. Dr. Osler said this was the oldest person in whom he had found Pernicious Anæmia.

Physometra.—Dr. Ross gave the following particulars: Was sent to attend a woman in labor; was told she had had a rigor some hours previous. Found she had fever and rapid pulse. Abdomen much distended, not much pain, but complained of distressing feeling of tension. Percussion over uterus was as resonant as the stomach. Said did not feel movements of child. Diagnosed dead fœtus and uterus filled with gas. Patient was delivered same night. It was a breech case. Had some diffi-

culty to get child through, as its abdomen was filled with gas also; had to use a fillet. With each contraction of uterus detonations of gas and gurgling took place. As the head was delivered, most frightfully offensive gas came away. The child was much decomposed. Had never seen a similar case, and why so in this case, or why not oftener seen when the fœtus dead, he could not say. Patient recovered fully. No disinfectant was used at any time.

Dr. Roddick read a report of two cases of *Purpura Hæmorrhagica*, ending fatally, of which the following is a brief abstract:

Case I.—Early on the morning of Sept. 21st, of last year, I was called to see a child, aged 7 years, said to be suffering intense pain in one eye, which was also swollen. I learnt on the way that the little girl, who had just recovered from an attack of scarlet fever, had been brought from Quebec the day previous, and appeared to be pretty well, but on going to bed was noticed to be feverish, and had vomited. The mother was aroused about midnight by the cries of the child, and noticed immediately that the right eye was considerably swollen and the lids ecchymosed. I found the upper lid especially enormously distended with blood, while on the cheek was a discoloration of the same nature. She had not passed urine for some hours, if at all during the day. Pulse weak, but not rapid; temperature was not taken. Ordered iced cloths to be applied to the ecchymoses, and internally, gallic acid, with iced milk as food. 8 *a.m.*—Ecchymoses previously noted not increased in size, but others have appeared over the body and limbs. Urine passed is found to be almost pure blood; slight epistaxis; no fever; pulse weak. Dr. R. P. Howard saw the case in consultation with me during the day, but in spite of the most strenuous efforts on our part, the patient rapidly sank, and died within twenty hours of the time I was first summoned. An autopsy could not be obtained.

Case II.—Mrs. —, a widow, in fair circumstances, aged 45, mother of six children, the youngest 10 years of age, consulted me for the first time on Feb. 26th, of this year, for a troublesome nose-bleeding. She had always enjoyed good health; menses regular; bowels in good order, but considerable flatulency and

other dyspeptic symptoms. She stated that her teeth had been bad for some months, and on that account she seldom ate meat or other food that required much mastication. Ordered her suitable tonic treatment, and recommended an astringent douche for the epistaxis. She returned in about a fortnight, not much improved in general health, although the epistaxis was better. She now stated that she was spitting blood. On examination of the mouth, noticed a remarkably spongy condition of the gums, which bled on the slightest pressure. Suspecting the nature of the case, had the body examined, and found three or four ecchymotic spots, of the size of a sixpenny piece, on various parts. Ordered ice for the gums, and a strong solution of tannin, with gallic acid and ergot in large doses, internally; the food to be of the most nourishing and concentrated kind.

March 15th–18th.—Patient weak and blanched; the bleeding from the gums continues; requested Mr. McGowan, dentist, to see the case, with a view to having some pressure applied to the gums. At my suggestion, two loose teeth in the lower jaw were removed, and the bleeding from around them, which was excessive at times, was subsequently kept under control. Perchloride of iron was applied freely, and a cast of the gums was taken and adjusted so as to exert pressure. Vomiting and abdominal pain became now troublesome symptoms, and demanded special treatment. The spots of extravasation increased in size and number, appearing especially on the lips, eyelids, chest, buttocks, thighs, and upper arms. Up to this time there had been no blood in the urine; the stools were noticed to be black, but that may have been from the iron employed locally. Turpentine was subsequently administered in ten minim doses. As the vomiting persisted, the food was introduced *per rectum*.

March 21st.—The patient died this evening, no change for the better having occurred at any time during the past two days. Drs. Fenwick and Howard saw the patient with me, and each gave a most unfavorable prognosis. During the last few hours of life, the urine, which was very scanty, contained a trace of blood. The patient died of asthenia.

Empyema, Discharging Through Lung, Recovery.—Dr.

Osler related the following particulars of this case: Man admitted into hospital under his care with typhoid fever. During convalescence found dullness at base of right lung, which a week later reached to spine of scapula. Effusion well marked; with hypodermic syringe drew off about 20 minims of pus. Waited for a week before treating with canula and when about to do so found him spitting pus in large quantities—as much as 10 to 15 ozs. in the day. Physical signs became less marked, dullness diminished, moist sounds over that base; resonance not yet natural. Pus not fetid. Diagnosed erosion of Pleura and soakage of pus through lung tissue in the bronchi. There was no pneumothorax. Dr. Osler said that the late Dr. R. L. MacDonnell of this city was, he believed, after Hippocrates, the first to notice the occurrence of perforation into the lung in empyema, and recorded seven or eight cases. Traube in 1871–72 claimed to be the first, but was mistaken. Traube was fortunate in having a post mortem on one of his cases where the pus was seen soaking through the lung tissue.

Dr. Ross mentioned three cases of complete cure of empyema by erosion of Pleura and soakage which had come under his care.

Dr. Wilkins believed in operating early in cases of empyema, had had good results from excising about two inches of a rib.

Drs. Molson and Gardner had each seen a case similar to Dr. Osler's.

Pyometra.—Dr. Gardner gave the following particulars: Patient, aged 60, complained of pain in hypogastrium; was losing blood and an ichorous fluid from the uterus; had good health till year previous. Uterus was large; probe entered through ragged tissue into uterus 3½ to 4 inches. Nothing but blood coming away; put in a tent. Was inclined to think the case one of maglignant disease. On removing tent next day, a teacupful of pus, not fœtid, was discharged. The curette brought away granulations from the cervix. The cavity was smooth. The nature of the granulations was obscure. The uterus was washed out with iodine lotion. Patient got perfectly well, and has had no return of the disease.

Dr. Osler mentioned having met "post mortem" with three or four cases of uteri filled with pus, and having occlusion of inner os.

RIDEAU AND BATHURST MEDICAL ASSOCIATION.

Of the many local associations throughout Canada, few show greater vitality than the "Rideau and Bathurst," formed of members of the College of Physicians and Surgeons of Ontario, residing in that district. Its meetings take place twice annually; in the winter at Ottawa, and in the summer season at one of the rural towns; at all of which the surrounding country is well represented, the members evidently appreciating the value of such gatherings.

On Wednesday, June 27th, the tenth annual meeting was celebrated at Arnprior, the residence of its President; Pembrooke, Cobden, Arnprior, Pokenham, Almonte, Bearbrook, Carp and Ottawa being represented.

The proceedings were opened by Dr. Cranston delivering his annual address. Besides referring to matters of interest to the profession in general, and of his locality in particular, he made a lengthy report of his duties as representative to the Ontario Medical Association.

Pamphlets and circulars issued by the Provincial Board of Health were distributed among the members.

The following officers were then elected for the ensuing year:

President, Dr. Cranston, Arnprior; 1st Vice-President, Dr. Malloch, Ottawa; 2nd Vice-President, Dr. Groves, Carp; Treasurer, Dr. Hill, Ottawa; Secretary, Dr. Small, Ottawa; Council, Drs. Dickson, Pembrooke; Burns, Almonte; Armstrong, Arnprior; Bell, Bearbrooke; Rattray, Cobden; Baird, Pakenham; Grant, Sweetland, and H. V. Wright, Ottawa.

Dr. McFarlane, Almonte, presented a paper upon the management of the bowels in Typhoid Fever (which will be published in this Journal.) A lengthy discussion ensued, the general tone of the remarks favoring the views advanced by the reader—that the bowels should not be allowed to become constipated in that disorder.

Dr. Groves read a paper upon "Some cases of Lead Poisoning that had appeared in his practice," which also provoked much discussion. These cases were brought under the notice of the Montreal Medical Society by Dr. Girdwood, at one of its meetings recently.

A case of gunshot injury was reported by Dr. Burns, where a small bullet had penetrated the abdomen just above the umbilicus, passed through the body, and escaped a few inches from the vertebral column. With the exception of a slight attack of peritonitis of short duration, recovery was rapid and perfect.

The discussion that followed was directed to abdominal surgery. Drs. Ward (Arnprior) and Malloch (Ottawa), ex U.S. Army Surgeons, cited many instances of recovery from bullet wounds, the latter gentleman having had one case where fæces escaped through the opening of exit. Dr. Dickson had met with many remarkable cases of abdominal injury with recovery, and believed that no matter how hopeless the case appeared, it was the surgeon's duty to attend to all the minutiæ as if recovery was undoubted. Many others present continued the remarks.

After passing the usual votes of thanks, the members adjourned, to meet at Ottawa in the second Wednesday of January.

Extracts from British and Foreign Journals.

Unless otherwise stated the translations are made specially for this Journal.

Renal Inadequacy.—In an address on this subject recently delivered before the Metropolitan Counties Branch of the British Medical Association, Dr. Andrew Clark, Physician and Lecturer on Clinical Medicine, London Hospital, and President of the Clinical Society, stated "There is a certain state of the kidney in which, without any alteration of structure that the eye can detect, it can, nevertheless, not produce a perfectly healthy urine. It is an urine low in density and deficient in solid constituents, principally urea and its congeners. I call this state renal inadequacy. You may say 'It seems scarcely wise to introduce a name like that, when probably it is nothing less than an early state of Bright's disease. Why bring

in another name?' I will not say that it is not an early stage of Bright's disease; I do not know. I think it need not necessarily be; but I shall assume that it is, perhaps, a very early stage of Bright's disease. I nevertheless think it of practical value—and we who are here to-night are practical men—to recognize by a distinct name a state which may remain as it is during the whole period of life, which is nevertheless capable of removal, and which, if unnoted, may lead to serious injury to the patient. Let me explain. The people who have this renal inadequacy are characterized by three things particularly. First and foremost, they are characterized by a curious inability properly to repair damages done to them either by accident or by disease. I have no doubt you as well as I have often been puzzled to know why, in particular cases, they could not repair a common accident; or why, in a disease such as pneumonia, the exuded stuff was not melted and speedily swept away; why a man who had met with some trifling accident in the wrist or shoulder remained suffering from it. Then, they not only repair damages of this kind slowly, but they are peculiarly vulnerable. They are a people, as a rule, who are always catching cold, and who, when they catch cold, come within the category of the first characteristic—namely, that they do not get rid of the cold. They are the people who, without apparent reason, and without other existing disease, get pneumonias, pleurisies, pericarditis, and the like. Then, thirdly—and, I think, almost the most important thing to be noticed about these cases—you can never be sure of the result of the performance of an ordinary surgical operation upon them. It is this class of people, as I had the opportunity a few years ago, in London, of discovering, that die from a simple operation by hæmorrhage. It is this class of people who have an abscess opened and immediately become what is called pyæmic. It is this class of people who, without his being able to explain it, attracted the notice of that distinguished surgeon, Sir James Paget. Some years ago he said, "Whenever I find a man in ill-health, without definite cause for the ill-health, I feel sure that my chances of success in operating upon him are diminished by at least one-half."—*British Medical Journal.*

The Treatment of Spermatorrhœa.—Dr. H. Coupland Taplor writes, in the *British Medical Journal:* Obstinate cases of spermatorrhœa and frequent nocturnal emissions constantly come under the care of the practitioner. Too frequently the medical man consulted simply tells the patient that if he breaks off the pernicious habit of masturbation, which has probably originated his malady, he will soon quickly recover. But in fact, in most cases, the habit has already been abandoned before he comes to seek advice; and these cases do not get well for months or even years afterward, unless proper measures be taken. Knowing that he has left off this bad habit, and that he nevertheless does not improve, his complaint being made light of by the regular practitioner, and being greatly depressed in mind, he seeks the advice of the quack, who is always ready to benefit by these cases. I will give an outline of the treatment I have followed, and which I have found most successful in several such cases. The treatment should be: (1) Moral, (2) Hygienic, (3) Medicinal.

1. *Moral.*—(*a*) The pernicious habit of masturbation, which has probably been the origin of the complaint, must at once be discontinued, or no good results from any treatment. (*b*) The thoughts should be directed from himself by his having regular work and exercise. (*c*) The anxiety of mind which ensues should be allayed as much as possible and a happy state of mind instituted.

2. *Hygienic*—(*a*) The patient should have regular but not excessive mental employment, and bodily exercise in the form of walking, riding, or out-door sports and games. (*b*) Cold sponging of the genitals night and morning for some minutes, or as long as can comfortably be borne, is a most important agent in giving tone to the relaxed organs. (*c*) The patient should have a hard mattress, and as little and as light clothing as possible at night. Care should be taken not to lie on the back, which may be prevented by wearing a knotted towel over the spine, or by some other device. (*d*) No quantity of liquid should be taken before retiring to rest, and the bladder should be emptied the last thing.

3. *Medicinal*—A mixture containing tincture of perchloride

of iron and tincture of nux vomica should be given twice or three times a day; also a pill containing a fourth or a third of a grain of extract of belladonna with three grains of camphor should be given at first every night, and then every other night, immediately before going to bed. If these lines of treatment be adhered to, the patient, whether suffering from real spermatorrhœa, or simply from frequently returning nocturnal emissions, will steadily improve, and the emissions will occur less and less frequently, till, in the course of a few weeks, or possibly months — for a malady of long standing (as this usually is) is never cured immediately—they will cease altogether, or only occur at such intervals as may be deemed normal, and in which there is no harm whatever.—*Louisville Medical News.*

Inheritance of Cancer.—In the course of a paper on the Local Origin of Malignant Growths, read in the Section of Pathology at the last annual meeting of the British Medical Association, Mr. Jonathan Hutchinson observed: "It is needful to say a few words as to the inheritance of cancer in its bearings upon the doctrine of its local origin, since an adverse argument has been founded upon it. It has been urged with much plausibility, that a disease which is capable of inheritance must be a constitutional one. No doubt, to some extent, this is true; but the argument must not be pushed beyond its legitimate scope. The laws of inheritance, as with property, so with property, so with disease, concern convection, and not origin or production. The inheritance of a fortune is a very different thing from its acquisition, and gives us no clue as to how that may have been accomplished. The causes of cancer, as we meet with it in practice, may, perhaps, be usefully classed as three: Senility of tissue, local irritation and inheritance. Of these, only the first two can rank as true causes; the latter, although practically of great importance, is only a model of perpetuation of that which the other two have originated. Senility gives proclivity, local irritation excites, and subsequently hereditary transmission may perpetuate. The facts, as regards chimney-sweeps' cancer, gives perhaps the best illustration of what I mean. Before this malady was practically suppressed by Act

of Parliament, I believe it was commonly noted that when the trade of sweep went, as it often did, in a family, proneness to suffer from soot-warts, and for soot-warts to degenerate into cancer, increased in successive generations. Grandsons and great-grandsons were attacked at earlier ages, and with much greater frequency than those who were new to the trade. Here, then, we observe the liability to a form of cancer, produced in the first instance by a local cause, perpetuated and intensified by hereditary transmission. We witness the genesis of cancer, and see the shares taken by local irritation and inheritance, and how entirely secondary the latter is as regards the former. If we ask what it is which is inherited in the case of the transmission of cancer, probably the nearest approach to an answer which can be given will be to say that it is a peculiarity in cell-structure generally ; not germs, not a blood-malady, but a special type of cell organization, permitting, with greater ease than in other persons, the injurious influence of local causes. Even in the sweep, whose forefathers have suffered from soot cancer, the transmitted tendency still waits for the exciting cause ; and the disease occurs, not in internal and, therefore, protected parts, but on the same part as it did in his great-grandfather, and under the direct influence of exactly the same cause. Not that I would for one moment doubt that, in some instances, the inherited proclivity may be so strong, that it does not wait for the help of any exciting causes, but manifests its power in the production of a cancer which may be considered spontaneous. It is probable in this way that we ought to explain almost all cases of cancer occurring in very early life ; and it may be the fact that, in a few of these, something more definite than mere tissue proclivity may be transmitted, possibly even germinal matter, especially in those cases in which the parent was the subject of the malady. Thus, then, although I fully admit that in the examination of our patients we must make large allowance for the influence of inheritance, I wholly deny that we can allow it rank as a true cause of cancer."—*British Medical Journal.*

Cascara Sagrada in Constipation.—J. Fletcher Horne, F.R.C.S., writes:—"*Cascara Sagrada, Rha-*

mnus purshiana, is a small tree indigenous to the Pacific, Coast of North America. The fluid extract I have used is that prepared by Parke, Davis, and Co., Detroit, procurable of their agents, Messrs. Burgoyne, Burbidges, and Co., London. Its use, in my hands, seems to be indicated in almost all cases of constipation, particularly in cases of torpidity of the liver, with scanty dry stools and indigestion. It seems to act as a stimulant to muscular fibres of the intestines, through its action upon the sympathethic nerve, this increasing the vermicular movements of the intestines, thus resembling nux vomica. I have used it in several cases of obstinate constipation with very satisfactory result. I generally give twenty drops three times a day in sweetened water for ten days or a fortnight; and then, gradually reducing this dose, the patient is able to establish a habit of regularity. Given in doses of a teaspoonful, it acts as a gentle purgative, without producing any griping, tenesmus or nausea; but its action is slow, and, in this sized dose, seems to lose its good property of curing the constipation. With children, with smaller doses, I have had equally good results." —*British Medical Journal.*

Extraordinary Customs of the Aborigines of Central Australia. By JOHN M. CREED, L.R.C.P.—At various times, and from various absolutely trustworthy sources, particulars of the following singular custom have come to my knowledge. Throughout the whole of the interior of the continent, from the eastern boundary of the watershed of the Georgiana river on the east to nearly the settled districts of Western Australia on the west, and from the coast range on the north to Cooper's Creek watershed on the south, the men have an artificial opening in the inferior wall of the urethra, just anterior to the scrotum; in some tribes this opening is only from one inch to one inch and a half long; in others the whole of the posterior wall is removed, so as to absolutely destroy the canal from the scrotum to the base of the glans penis. In copulation the semen is, of course, emitted at the inferior end of this opening, external to the vagina of the female, so that impregnation by sexual intercourse with the men

so operated on is impossible, and this effect seems to be the desired end for which the operation is performed. From inquiries made by my informants (pioneer settlers) of partially civilized blacks who themselves had been operated on, it seems that the period of life at which this custom is carried out differs in various districts; in some it is done to the boys about the age of puberty, in others to the men at a more advanced period of life. Hume, when he returned to Sydney in 1873, gave the first account of this custom, which came to my ears. He said that tribal laws as to the possession and occupation of hunting country, are so rigidly carried out, that no tribe, however much in want of food, dare go beyond the limits of its own territory, and that, consequently, it had become necessary, in some way, to check the ordinary increase of population. To do this he said every black fellow was allowed to procreate two children, and that then by the laws of the tribe he was, by operation, rendered for the future sterile, though not impotent. He said also that the gins (women) after producing the same number of children were, by some operation, rendered sterile for the future. Another gentleman, an ex-Minister of the Crown, was able to furnish me with some particulars. To render the woman sterile they insert a stick, and sometimes in addition, hair into the vagina, and presumably into the uterus; this, the blacks say, produces the desired effect. Probably the way it does so is by setting up adhesive inflammation in the fallopian tubes, and thus causing closure of their canal, rendering the passage of the ovum impossible. Either at the same time at which the stick is inserted into the uterus or afterwards, I have not been able to ascertain with accuracy which, the woman when lying on the ground has her abdomen kept continually covered with very hot sand, heated by fire, kept on as hot as it is bearable. The mortality amongst the women is said to be about one in six. A third friend (whom I have known since boyhood, and whose truthfulness is undoubted), tells me that in Sept., 1882, at a place in latitude 22° south, and longitude 137° east of Greenwich, an exploring party under his command came across and examined 50 natives, comprising men, women and children.

The men were all operated on, and the women, with the exception of the younger ones, had their nipples cut off. He engaged three of the boys who were about the age of puberty, and who had been operated on within two or three days. One of these boys told my informant that the boys were as a rule operated on at that age, and that they were very proud of it, but that some members of the tribe were left unoperated on for the purpose of procreating children to continue the race, and that these were very "saucy fellows." The rite is, at all events amongst this tribe, performed with considerable ceremony, the boys pointing out an enclosure of some 30 feet square, with thick walls of brushwood some six feet high, near a running stream, as the scene of operation, and as being always erected for the purpose. Another settler who had every opportunity for knowing, tells me he learnt that these non-sterile men lived in a district by themselves, and that the women, when their impregnation was desirable, were sent to them for the purpose. Dr. Robertson tells me he has examined similar cases in Borneo, where it is a custom of the "Kyan" tribe. The late Mr. E. Hill also found it to be a custom of one of the islands he visited in the Pacific. It is an interesting speculation as to how this curious custom has arisen. I think the most probable explanation is, that at some remote period an individual was born with that rare malformation of the urethra "Hypospadias," and that some intelligent man amongst the tribe realized the possibility of producing the same thing by operation. It is likely that prior to this, the numbers were kept down by simple infanticide. All the individuals examined were found, in addition, to have been circumcised. The instrument used for both operations is a chip of flint formed into a knife.—*Australasian Medical Gazette, February.*

A Novel Agent in the Radical Cure of Hydrocele.—J. E. W. Walker, M.R.C.S.E., L.S.A., late H. M., 55th Regt., writes:—"In bringing this matter before the profession, I feel bound to admit that, but for a curious accidental circumstance, the agent might never have presented itself to my notice. In the year 1875, I proposed to operate

upon a patient, aged 65, for the radical cure of hydrocele of the tunica vaginalis. The disease had existed for about ten years, and had been repeatedly emptied by other surgeons. At this time I removed, by the trocar and canula, about twelve ounces of serum, and, by accident, took from my pocket a bottle containing about two drachms of liquor ergotæ(Battey) in the place of the same quantity of tincture of iodine, which it was my intention to throw into the cavity. On my return home, I discovered the mistake, and watched the patient for some hours at intervals. No inflammatory state occurred, and there was an entire absence of pain, so that I allowed my patient to return to his ordinary occupation the next morning. To the present time there has been no return of the abnormal secretion. I have since, on two occasions, used the same plan with perfect success, and I attribute the cure to a specific action, exerted by ergot which re-establishes the balance between secretion and absorption."—*British Medical Journal.*

Tracheotomy about to be Performed on Account of Labor Pains.—Dr. W. E. Steveuson, in the last number of St. Bartholomew's Hospital Reports (*Brit. Med. Journal*, May 19th), relates a remarkable case where a patient concealed the fact that she was in labor, and the only objective symptoms that were observed appeared to justify the operation of tracheotomy. He was requested, as house-surgeon, to operate, but the dyspnœa did not appear to be like that which he had relieved by tracheotomy in previous cases, and after waiting a few hours, much to the annoyance of the senior medical officers connected with the case, the patient was delivered of a male child.

Hypophosphites prepared with Glycerine.—Dr. C. G. Polk (*Virginia Med. Mouthly*) has been using for the past year the following preparation, which he prefers to the syrup of hypophosphites :—

Ferric hypophosphite, gr. 128 ; Manganese, gr. 48 ; Calcium, gr. 128 ; Sodium, gr. 96 ; Quinia, gr. 64 ; Strychnia, gr. 2. Add pure glycerin, sufficient to make one pint ; Solution of hypophosphorous acid, sufficient to dissolve the iron. Dissolve the iron in one ounce of water acidulated with hypophosphorous acid ; add the hypophosphite of manganese dissolved in one ounce of water, then the lime, soda, quinia and strychnia, and the required amount of glycerin.

CANADA

Medical and Surgical Journal.

MONTREAL, JULY, 1883.

THE TRIENNIAL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS, P. Q.

The Triennial meeting of this College was held in the buildings of the Laval University at Quebec, on the 11th inst. The President, Dr. R. P. Howard, took the chair at 10.30 There were present:—Drs. R. P. Howard, Leonidas Larue, A. G. Belleau, Chas. Verge, Z. Gravel, A. Larochelle, Jos. Theberge, G. B. Lafleur, W. Lamontagne, F. W. Campbell, W. H. Hingston, Jean L. Leprohon, H. Sauve, Wm. Osler, Geo. Ross, T. A. Rodger, J. A. Ross, P. Lachapelle, D. B. Desaulniers, Tancrede Fortier, G. Lachance, Regis Latraverse, C. E. Lemieux, sr., J. A. Sewell, G. O. Beaudry, Jos. Lanctot, N. H. Ladouceur, Arthur Robitaille, A Marois, Jos. Langlois, V. P. Lavallee, E. P. Chevrefils, Malcolm Guay, G. H. Dufresne, W. Marsden, J. P. Lavoie, Achille Gauvreau, L. Catellier, Geo. Bolduc, E. Gervais, Chs. Gingras, Alf. Dion, N. Lacerte, J. E. Ladriere, J. B. Bolduc, E. A. de St. George, C. S. Parke, S. Gauthier, J. B. Gibson, J. A. S. Brunnelle, David A. Hart, F. E. Roy, Jos. Marmette, Alf. Morissette, Falardeau, S. Bolduc, Emm. E. Duquet, Edouard Belleau, E Badeau, J. B. A. Lamarche, J. M. Turcot, Gasp Turcot, Edwin Turcot, J. B. Bolduc, R. F. Rinfret, A. Jackson, F. R. Rinfret, F. D. Gilbert, P. Wells, A. Watters, W. A. Verge, O. Mazurette, J. Marceau, P. A. Shea, M. J. Ahern, F. J. Austin, Henry Russell, V. St. Germain, Luc. Beauchesne, M. Fiset, Aug. Hamel, E. Morin, A. Vallee, C. Cote, A. Poliquin, F. X. Gendron, Nap. Lavoie.

The minutes of the last Triennial meeting were read and

approved. The Treasurer's report, showing a very satisfactory state of the finances, was read and adopted.

The President then read the following address :—

Members of the College of Physicians and Surgeons of the Province of Quebec,—Gentlemen :—The term of office of the present board of governors of the College terminates to-day, and a short retrospect of the proceedings of the Board during the past three years, and of any events of importance in the history of the institution of which we are all members, may be of some interest to you—and is doubtless expected from me as your presiding officer.

The last triennial period of the College history has not been characterized by any remarkable events. The Medical Act of 1876 (40 Vict., chap, 26), which was the model and basis of the existing Act, and the joint product of the Medical Board and the Medical Institutions of this Province, was, as you know, further amended, and passed almost exactly in its present form on October 1879 ; and its by-laws were sanctioned by His Honor the Lieut.-Governor on the 3rd Sept. 1880. It has been, therefore, the humble but important function of the retiring board during its three years of office to administer the affairs of the college in accordance with " statutes, rules and regulations," which had been just completed and transmitted to it by its predecessors.

One of the first acts of the Board at its first semi-annual meeting was to appoint an officer whose special duty it is to institute legal proceedings against persons infringing the provisions of the Medical Act, and as will presently appear from the report of that officer, a *systematic* effort has been maintained during the past three years, for the first time in the history of the College, to prosecute persons practicing the medical art without legal qualifications in the Province of Quebec.

As a summary of that report I may here state that 49 suits were instituted by the agent of the College ; 35 of which were successful, and 9 were lost through want of evidence ; 2 through exception to the form ; 1 through the plaintiff's lawyer failing to appear in court ; and 2 because the defendant *possessed the*

Governor's license, and the court was of the opinion that that was a Royal privilege and exempted him from the operation of the Medical Act.

When the many difficulties which attend the establishing of criminality in courts of justice—I was going to say in a legal way, when these many difficulties, some of them legal, some of them social, and I regret to say some of them of our own making—are borne in mind, it will be admitted that something has been done ; at least a good beginning has been made to protect the members of the College in the enjoyment of their professional rights. And I have the hope that with the experience of the present system during the last three years to serve as a guide, this department of the College work will be yet more satisfactorily carried on during the coming triennial period. Mr. Lamirande has collected $367 for registrations, $260 for licenses, and $3,092 for annual subscription—making a sum of $3,719.

From the reports of the Matriculation Examiners it appears that 142 candidates have been admitted to the study of medicine during the last three years. The efficiency with which this important function of the College is performed, is proved by the considerable number of young men who are remanded to their studies at the preliminary examinations—and there is little doubt that under the present system the educational qualifications of persons entering upon the study of medicine must gradually attain a higher general average than under the old system.

One hundred and fifty-three (153) licenses to practice in the Province have been issued during the triennial period now under review. One hundred and forty-four (144) of these were given to graduates of the Medical Institutions of this Province ; two to licentiates of Ontario ; two to graduates from Great Britain ; one under clause 24 of the Medical Act to a practitioner over thirty years practice in the Province ; and four to gentlemen presenting themselves before the Board for examination. Two candidates for the license were referred to their studies.

A medical tariff adopted by the College, after due considera-

tion on Sept. 1880, was approved by the Lieut.-Governor in Council on May 1881; but was repealed by the Provincial Legislature early in 1882, owing to the opposition made to it in some districts by the electors, on the ground that the tariff was too high. The governors resident in the cities of Quebec and Montreal made a vigorous effort to have the Medical Act amended by the insertion of a clause giving power to the members of the College to form distinct associations, which should have the right to make a tariff for their respective districts, subject to approval by the Provincial Medical Board; but this also failed. The Act, however, remains unchanged, and the College has the right to make a tariff subject to approval by the Lieut.-Governor-in-Council.

It is quite possible that hereafter a tariff which shall embrace only a few of the ordinary items, such as visits, consultations, certificates, mileage, etc., may be prepared that shall be acceptable to the Lieut.-Governor-in-Council—*i.e.* the ministry of the day; but may I be permitted to remind my colleagues that while a tariff under such sanction has important uses, the chief of which is to protect alike the interests of the public and of their servants—the physicians—the profession must after all make its own rate of charges; and there must be no undermining of a brother's reputation, no underselling to attract patients, no contracts for wholesale attendance and cheap medicine; such practices may do for hotel touters, for representatives of bogus insurance companies, but are unworthy of the members of a liberal profession.

If a medical society were established in the various districts, a fair sale of fees might be agreed upon amongst its members as adopted to the social condition of the inhabitants, and usage would give such scale the force of law, if the members of the profession would favorably assist one another. I do not mean to overcharge, but to charge a reasonable fee for valuable service.

As becomes a body representing the profession of medicine —a profession the constant aim and desire—*raison d'etré* of which is to preserve life, prevent disease, and avert death; the

Provincial Board at its May meeting in 1882, passed a resolution approving of a bill then before the Provincial Parliament dealing with the great subjects of Public Health and Vital Statistics, and respectfully recommending the Legislature to give the principles of the bill its most serious consideration. Perhaps in no way, outside the discharge of their professional duties to their patients, can members of the College and of the Provincial Board do more for the general good than by using their respective personal and official influence with our legislators to pass laws dealing with questions of public health and vital statistics.

During the session of the Provincial Legislature held in 1882, a few amendments to the Medical Act were suggested by the gentleman who was acting as the legal adviser of the College, intended to facilitate the methods of procedure in the courts against persons infringing the provisions of the Act. These amendments will be found in the 2nd, 6th, 23rd, 28th and 32nd sections of the existing Act; and another at the end of section 15, which was based upon a resolution of the Provincial Board, passed at a semi-annual meeting. This last amendment secured the important principle that medical students shall attend a course of lectures during the fourth year of their professional studies, and shall not pass an examination upon the great final subjects of the curriculum until the close of the session of their fourth year.

These several amendments were submitted to the Governors residing in Quebec and Montreal; and having received their approval were introduced by the Hon. Mr. Mercier, and were passed by the Legislature.

A correspondence having appeared in the public papers some time ago to the effect that private examinations are given by Professors connected with a medical school in this Province, and that on these examinations, certificates are issued purporting that the bearers are entitled to a diploma, and are in fact medical practioners, a Committee of the Governors was charged with the duty of investigating the statements, and it is gratifying to be able to report that no evidence could be elicited to sub-

stantiate them, and that the Board unanimously voted them untrue.

The importance of watching closely the proceedings of the Provincial Legislature has been upon former occasions brought before the College, but the insertion of the following clause in an Act passed last session entitled, "Acte pour amender et refondre l'Acte Incorporant l'Association des Dentistes," etc, is such an obvious disregard of the rights and welfare of the medical profession in the interests of one or perhaps a few individuals that it ought not to be overlooked in a review of the history of the College during the last three years. The clause is as follows: " Et nonobstant les dispositions de la Section 8, de l'Acte 42-43 Victoria, Chapitre 37, (that is the Medical Act) toute personne pratiquant légalement l'art dentaire depuis dix ans et plus, avant la passation du présente acte, serra par le fait considéré comme admis étudiant en médecine et propre à suivre le cour et subir tout examen requis pour la pratique de la médecine dans les Universités ou Colléges de cette Province en ce conformant aux règlements des dit Colléges ou Universités." That is to say any person who shall have legally practiced as a dentist for ten or more years before the passing of the Dental Act of 1883, shall be exempt from a preliminary examination and may at once enter upon the study of medicine. That this piece of *modest* legislation was really intended to serve private interests, further appears probable from the fact that a letter was received by the Quebec Secretary of the College from a dentist applying for enregistration under the Act in question. I need hardly say that a committee of the College has been appointed to examine and report upon this subject.

The hand of death has not been idle amongst our colleagues during the last three years. Perhaps in no former like period have so many men of mark been removed from our ranks. Several of them have been distinguished as teachers as well as practitioners, and have left their personal stamp upon many of us—such were Francis Hubert Larue, Jean Gaspard Bibaud, Peter Munro, George W. Campbell, Aaron Hart David, and William E. Scott. Some of them had been president of the College,

such was the last named, and Joshua Chamberlain and Henry Russell. And some had been governors, as kind old Alexis Thomas Michaud, Chas. Timothe Dubé. And the following the list of members belongs to that useful and honorable body, the general practitioners of the Province: W. Boswell, Quebec; Ed. D. Bellean, Ste. Michel; J. P. Coutre, Montreal; Phillipe Charest, Beauport; Alphonse Deschamp, Montreal; Isaie Demers, St. Jean D'Orleans; Fiset E. P. Morrison, Nicolet; G. E. Fitzpatrick, St. Jerome; L. Ephraim Olivier, Ex. M.P., St. Ferdinand d'Halifax, François Ainé Paradis, Ste. Isidore, Dorchester; Onesime Pelletier, Ex. M.P., St. Charles, Bellechase; E. H. Paquet, Montreal; Gaspard H. Turcot, St. Hyacinthe.

These our brethren are gone before us, and we are left to carry on their work. Whether it be in watching over the interests of the profession we love, or in teaching the *Ars Medica*, or in the humble but God-like work of healing the sick and relieving the suffering, let us prove faithful to our trust.

It was resolved, that the President's address be printed and circulated amongst the members of the College.

It was then moved by Dr. Osler, seconded by Dr. Lachapelle, that it be a suggestion to the incoming Board of Governors to consider the question of having such changes made in the present method of conducting the elections, that at the next Triennial meeting, each separate district shall elect their own representatives. It was moved in amendment by Dr. Fiset, seconded by Dr. Ladouceur, that the mode of election be not changed, but that it be suggested to the new Board that the Medical Act be so amended as to give to each existing judical district, a number of representatives proportionate to the number of practioners therein.

A second amendment was proposed by Dr. Gravel, seconded by Dr. Roy. That the practitioners of each judicial district shall elect their own representatives, who shall be chosen from amongst the members resident in such district.

In speaking to the original motion, Dr. Osler explained that this was a matter which had been thought of for some time.

That many were strongly of opinion that the change would be beneficial in the way of creating a stronger interest, in the country members especially, in the affairs of the College—in affording an opportunity for the election of a representative by those best acquainted with the merits of the several candidates, and in preventing the control of the election from falling virtually into the hands of a small number of city men. Many of those present expressed similar views, and favored the principle of territorial representation Great opposition, however, was made to taking any definite action before the matter was once more laid before the general profession. After a long discussion it was moved by Dr. George Ross, seconded by Dr. Brunelle, That the proposals contained in the motions of Drs. Osler, Fiset and Gravel be referred to the incoming Board of Governors, be considered by them, and that a report with their views thereon be submitted at the next Triennial meeting.—Carried.

The ballot was then opened and continued until 5 p.m.

At 8 p m. the meeting was re-opened. The following were announced as the representatives sent by the various Universities:

Laval University, Quebec.—C. E. Lemieux and J. A. Sewell.

Laval University Montreal. — E. P. Lachapelle and A. Lamarche.

McGill University.—R. P. Howard and Geo. Ross.

Victoria University.—E. H. Trudel and W. H. Hingston.

Bishop's College.—F. W. Campbell and R. A. Kennedy.

Dr. Marsden, on behalf of the scrutineers, read the following list of elected governors:

City of Quebec.—L. Larue, A. G. Belleau, W. Marsden, C. S. Parke, E. A. de St. George and Henry Russell.

District of Quebec.—Lieut.-Gov. Robitaille, Côme Rinfret, Chas. Gingras, Malcolm Guay, P. E. Grandbois, Jos. Marmette and L. T. E. Rousseau.

City of Montreal.—T. A. Rodger and J. L. Leprohon.

District of Montreal.—Jules Prévost, P. E. Mignault, D. A. Hart, N. H. Ladouceur, J. A. Duchesneau, Jos. Lanctôt, E. Lafontaine, H. A. Mignault and E. Marcil.

District of St. Francis.—Thos. Larue, F. X. Paré and F. J. Austin.

District of Three Rivers.—D. B. Desaulniers, Hon. J. J. Ross and F. B. Dame.

A vote of thanks was then passed to the retiring president, Dr. Howard, and the late Board of Governors, for the energy and faithfulness with which the affairs of the College have been conducted during their term of office.

A meeting of the new Board was held immediately afterwards, and the following officers were elected :—

President, Dr. C. E. Lemieux ; Vice-President for Quebec, Hon. Dr. Ross ; Vice-President for Montreal, Dr. Hingston. Secretaries.—Quebec, Dr. A. G. Belleau ; Montreal, Dr. F. W. Campbell. Registrar, Dr. L. Larue ; Treasurer, Dr. E. P. Lachapelle. Examiners for the preliminary examination, Professors Miller, Howe, Verrault and Laflamme. Assessors.—For McGill University, Drs. Church and E. P. Mignault. For Bishop's College, Drs. Rodger and Leprohon. For Victoria University, Drs. Angus McDonnell and Ladouceur. For Laval University (Quebec), Drs. Marsden and Roy; (Montreal), Drs. John Reddy and O. Raymond.

The Board then adjourned until September next in Quebec.

SUMMER SESSIONS.

The eighth annual summer session of the McGill Medical School was brought to a close by the clinical examinations at the hospital on the 3rd and 4th. In 1876 there were only 20 students in attendance, about one-eighth of the class; the numbers have gradually increased, and this year 62 men, nearly one-third of the enregistered students of the school remained for the practical and clinical courses. Of these 39 were final men ; 6 were third year, and 17 were second year students. In Toronto the additional session held for the first time this summer, has been very well attended at both schools. At the meeting of the Ontario Medical Council last month, Dr. H. H. Wright moved that the summer sessions be made compulsory. Though the motion did not carry, good will come of it, and it certainly would

be no hardship if every student was required to take at least one extra session.

In the examination for the clinical prizes offered by Dr. Osler to the students of the summer session, the following paper was given :—

Part I.—Written Paper—2 Hours.

I.—Give a detailed account of the symptoms known as uræmic, with references to the cases you have seen.

II.—What is the Jacksonian epilepsy ? How would you proceed to locate, approximately, the lesion ?

III.—Discuss the special features in any four cases of pneumonia you have studied during the session ?

IV.—A. B., aged 43, a strong, well built man; served ten years in the army; for the past 12 or 15 years has been a blacksmith. Is a moderate drinker; has not had rheumatism or syphilis. General health has been excellent. For three or four months past has been short of breath, particularly on exertion, and he enters hospital complaining of this together with cough and inability to lie down. No œdema of feet; no albumen in urine. Area of heart's dulness increased: impulse diffuse; double murmur at base; visible pulsation in arteries. Your diagnosis. Discuss etiology, explain the symptoms; give prognosis and treatment.

V.—Describe some of the initial (preataxic) symptoms of tabes dorsalis.

VI.—Discuss the following case :—

I. S., æt. 7, admitted with membranous sore throat and a slight rash. Strong suspicion that it was scarlet fever. Throat symptoms predominate. There is albumen in the urine. After ten days illness, convalescence. Patient up and about for a week, when urine diminished in quantity, became highly albuminous, and contained numerous casts. Dropsy of legs set in. Breath a little short. Three days after onset of these symptoms, patient was found, at time of visit, almost cyanotic. Respiration, 65; pulse, 120, fair volume. Is conscious ; urine very scanty.

Part II.—1 Hour.

Report upon a case; diagnosis and treatment.

Part III.—20 Minutes.

Oral, including microscopical examination of blood, sputum, urine, etc.

The first prize (microscope) was awarded to G. A. Graham of Hamilton, Ont., and the second ($25 worth of books) to W. A. Ferguson, B.A., of Richibucto, N.B.

Personal.

J. B. Loring, M.D. (McGill, '83), left for London on 30th ult.

Drs. Covernton and Burns, of Toronto, spent a few days in town last month.

W. K. Ross, M.D.(McGill, '83), of Goderich, Ont., has gone to London to pursue his studies.

Dr. Lefebvre (late of Brockville), surgeon to the Algoma division of the C. P. R., was in town last month.

Wm. Stephen, M.D. (McGill, '81), has been elected one of the physicians to the Montreal Dispensary.

Dr. Logan, of Ottawa, has been elected President of the College of Physicians and Surgeons of Ontario.

E. McNeil, M.D. (McGill, '83), is practicing at Kensington, P.E.I., having taken the practice of Dr. Darragh of that place.

Dr. Jukes, late surgeon to the N. W. Mounted Police, has been appointed Registrar of the districts of Regina, Souris and Touchwood.

We regret to hear that by a fire on the 14th ult. Dr. Youker, of Sterling, Ont., lost many valuable effects, including his diploma, class tickets, etc.

We were glad to have an opportunity of meeting Dr. A. McLane Hamilton, of New York, the well-known neurologist, who was in town on professional duty on the 3rd and 4th.

Dr. Theophilus Parvin has been elected Professor of Obstetrics in the Jefferson Medical School, Philadelphia, *vice* Dr. Wallace. Dr. Bartholow succeeds the latter as Dean of the school.

—Dr. T. A. Foster of Portland, Me., was recently on a visit to this city on business connected with the Union Mutual Insurance Company, of which he is the principal medical officer.

Prof. Humphrey, of Cambridge University, the well-known Anatomist, has resigned the chair of Anatomy and taken that of Surgery. He has been succeeded by Prof. MacAllister, of Dublin University.

Dr. Sawyer of Chicago was in town for a couple of days last week (to see a case of "Railway Spine") in the interests of

the Chicago & Grand Trunk Railroad. We congratulate the Road in having its professional welfare in the hands of such an accomplished and able man.

George Herbert Burnham, M.D. (Trinity, '75), F. R. C. S., Edin., has returned to Canada after a prolonged absence, and intends practicing his profession in Toronto as an oculist and aurist. Dr. Burnham succeeded Dr. Buller in the Royal London Ophthalmic Hospital, and as at first junior and then senior house surgeon enjoyed for three years the unequalled advantages of that institution. He has since been on the continent at the great eye and ear clinics. It is a matter of congratulation when the graduates of our Canadian schools, after a prolonged course of study in a specialty, return to their native country to practice.

Medical Items.

—The Female Medical School at Kingston, has received sufficient money guarantee from citizens and others to ensure financial success.

—The British Medical Association meets in Liverpool on the 31st inst., Dr. Waters as president. Dr. Fenwick, the retiring president of the Canada Medical Association, leaves on the 21st to attend the meeting.

—An excellent pamphlet of 20 pages "On the Disposal of Sewerage," has been issued by the Ontario Board of Health for distribution throughout the province. The circulation of such literature will do much to educate the people on the laws of health.

— The Toronto school is receiving considerable public support. By a slip of the pen we stated in our last issue that the faculty was composed chiefly of "Trinity" School of Medicine Lecturers. We meant "Toronto". We wish, in the interests of the school, we could have said "Trinity and Toronto."

Sir Astley Cooper Triennial Prize.—Competitors must send their essays to Guy's Hospital before 1st January, 1886. The money value of the prize is £300. It is open to the whole world, and will be given for the best essay or treatise on diseases or injuries of the nerves and their surgical treatment, together with operations performed upon nerve trunks in the treatment of various diseases, and descriptions of the changes which ensue in the structures as well as in the nerves themselves from the operations.

F.R.C.P.—It is with much pleasure that we congratulate Dr. Osler, Prof. of Physiology in McGill University, upon his election as a Fellow of the Royal College of Physicians of London, Eng. As most of our readers are aware, this is the highest honor the profession can bestow. It always means the appreciation by the very best judges of good scientific work well done. The Canadians who have succeeded in winning this coveted degree are very few, and in each case the entire profession may consider itself honored by the selection of one of its members for such a marked distinction.

—The annual meeting of the Ontario Medical Council was held in Toronto on the 12th, 13th and 14th of June. The retiring President, Dr. Bray, of Chatham, in reviewing the work of the year made several important suggestions, particularly that of a uniform bill for all the provinces. The motion of Dr. H. H. Wright for compulsory summer sessions was not adopted by the Education Committee. The finances appear to be in a tolerably satisfactory condition; great difficulty is experienced in collecting the annual assessment fees, the arrears amounting to over $5,000. A committee consisting of Drs. A. A. Fenwick, Lavell, MacDonald Bray, Bergin, Cranston and Logan were appointed to review the curriculum of study.

—Walt. Whitman, the "Good Grey Poet" as his friends love to call him, has an ardent disciple in Richard Maurice Bucke, M.D., the able Superintendant of the London (Ont.) Asylum, who has issued a volume (D. McKay, Philadelphia), giving an account of his life and writings. A genuine Bohemian, without fixed place of residence or occupation, one period of his life is deeply interesting. For three years during the civil war, Whitman moved through the army hospitals as a ministering angel, nursing, cheering and consoling the wounded. His "Specimen Days" contains graphic descriptions of the horrors of that war, aggravated in many instances by imperfection and failures in the medical department. Of "Leaves of Grass" this is scarcely the place to speak, although there are those who think both author and his poetry peculiarly suitable for the

consideration of journals devoted to one section of medicine. That he ' rudely ignores and overrides the instinct of silence' on sexual matters, many think with District-Attorney Stevens of Boston, who interdicted the book, but his upholders say with much reason, " they who think they find him obscene, in truth find nature obscene, find themselves obscene." His admirers claim that he is the prophet of a new era and " Leaves of Grass," the gospel of a new dispensation—the Bible of Democracy. Lest any should fear the spread of such heretical notions, we hasten to add that according to one disciple, it takes seven years to appreciate the work, and Dr. Bucke himself for many months could see nothing in it, and after eighteen years does not fully understand it, indeed, has doubts if he ever will.

—Since the introduction of *Maltopepsyn* into the Dominion of Canada, some four years ago, its rapid and increasing demand, arising entirely through the support of the medical profession, until it now stands at the head of all remedies of its kind, proves conclusively its intrinsic merit and superiority of formula over all other digestive remedies. This is still further attested to by the signatures of nearly all the leading physicians of Canada, and the fact that during the past year it has met with the support of the profession in England, and is rapidly gaining a large sale throughout Great Britain. At this season of the year Maltopepsyn is invaluable as a specific for infants' troubles such as cholera infantum, etc.

Beef Peptonoids.—From the unqualified endorsement that this preparation has received from several of the leading physicians in the United States (particularly those who had charge of the late President Garfield), it is certain to receive much attention from the profession here. As a concentrated and partially digested food, its administration in the convalescent stages of any disease, whether by the mouth or per rectum, will, judging from the data before us, be followed invariably by the best results. The history of several cases is given in the *New York Medical Record*, in which this agent was employed most satisfactorily. For rectal alimentation it appears to have no equal. The composition of " Beef Peptonoids " (being a concentrated Powdered Extract of Beef partially digested, and combined with Gluten of Wheat), warrants its claim of being a most valuable nutrient; but in addition to this, it contains sufficient peptone to assist the digestion of any food that may be used at the same time, which materially increases its importance.

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The Montreal medical journal

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